

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 7 Film G92 8/25/67 kk  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>142 Yuma St., S. E.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JERRY MARK RAPILLO</b>		4. DATE OF DEATH Month Day Year <b>Aug. 17 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/24/1900</b>
9. AGE (In years last birthday) yrs. <b>66</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cafeteria Manager</b>	
11. BIRTHPLACE (State or foreign country) <b>Conn</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Angelo Rapillo</b>		14. MOTHER'S MAIDEN NAME <b>Mary</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW</b>		16. SOCIAL SECURITY NO. <b>381-09-5802</b>	
17. INFORMANT <b>Elizabeth Rapillo Same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO (b) <b>Coronary Artery Heart Disease</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>8/17/1967</b>	
ACTUAL SIGNATURE <b>Belden R. Rap</b> M.D. EXAMINER'S NAME (Type) <b>BELDEN R. RAP M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (City or town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/22/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wash. D.C.</b>		23d. LOCATION (City or Town) (County) (State) <b>Wash. D.C.</b>	
24. FUNERAL DIRECTOR <b>Ralph A. Mattingly</b>		25a. REC'D BY REGISTRAR <b>131 11th St. Wash. D.C.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>AUG 22 1967</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/58

11278

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

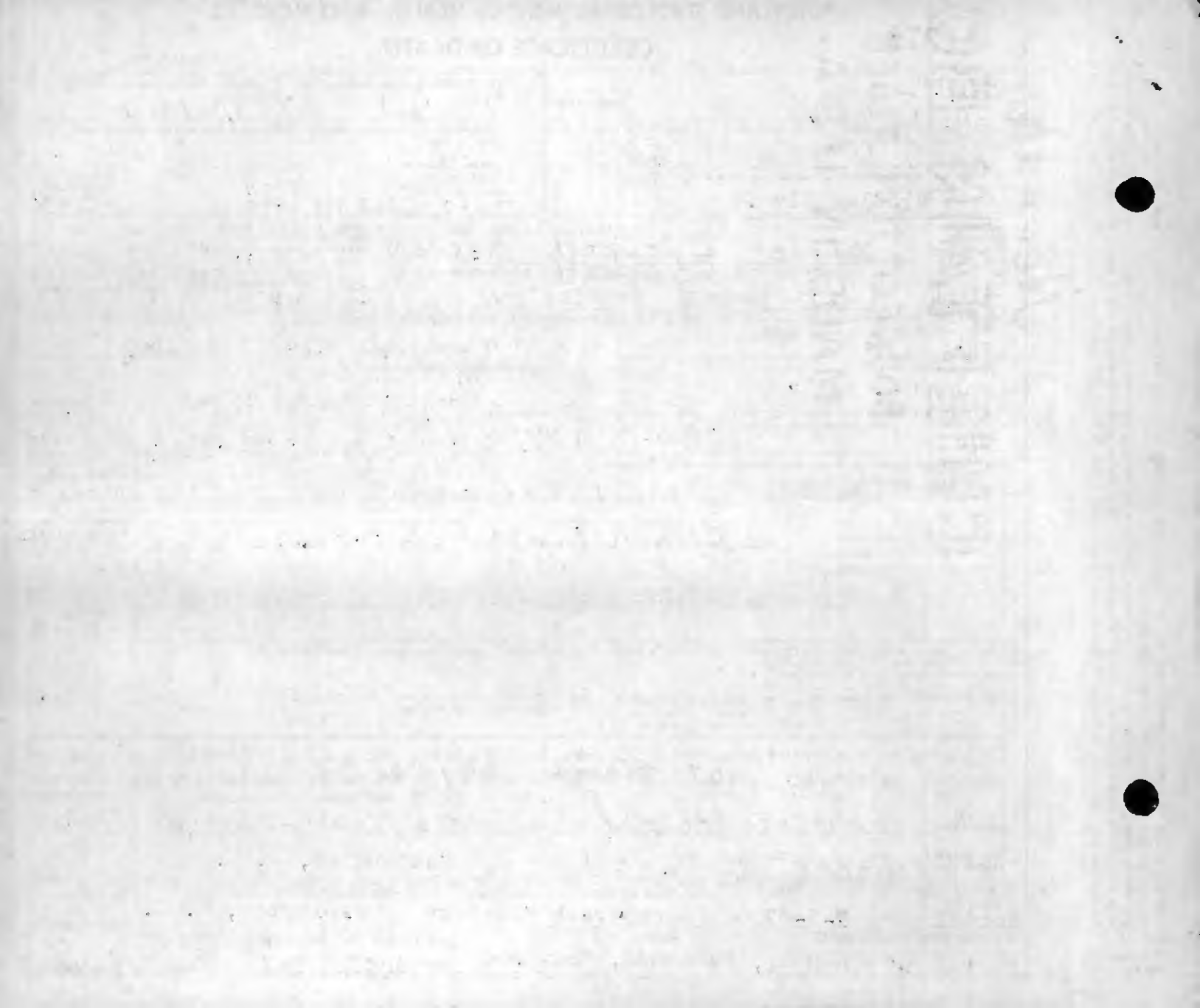
CERTIFICATE OF DEATH

11280

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>7yo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4743 Bradley Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mamie Elizabeth Reeves</u>		4. DATE OF DEATH Month Day Year <u>August 19 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1872</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. AGE (In years last birthday) <u>94</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>	
13. FATHER'S NAME <u>John W. Wells</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>Chronic Lymphatic Leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>15 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 2, 1966</u> to <u>Aug 19, 1967</u> , that I last saw the deceased alive on <u>Aug 18, 1967</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert B. Havell</u> M.D.		ADDRESS (Street, city or town, state) <u>5516 Nebraska Ave, NW</u> DATE SIGNED <u>8/19/67</u>	
PHYSICIAN'S NAME (Type) <u>Robert B. Havell</u>		Washington, D. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-5-67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> ADDRESS		24a. REC'D BY REGISTRAR <u>AUG 25 1967</u> 24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11280

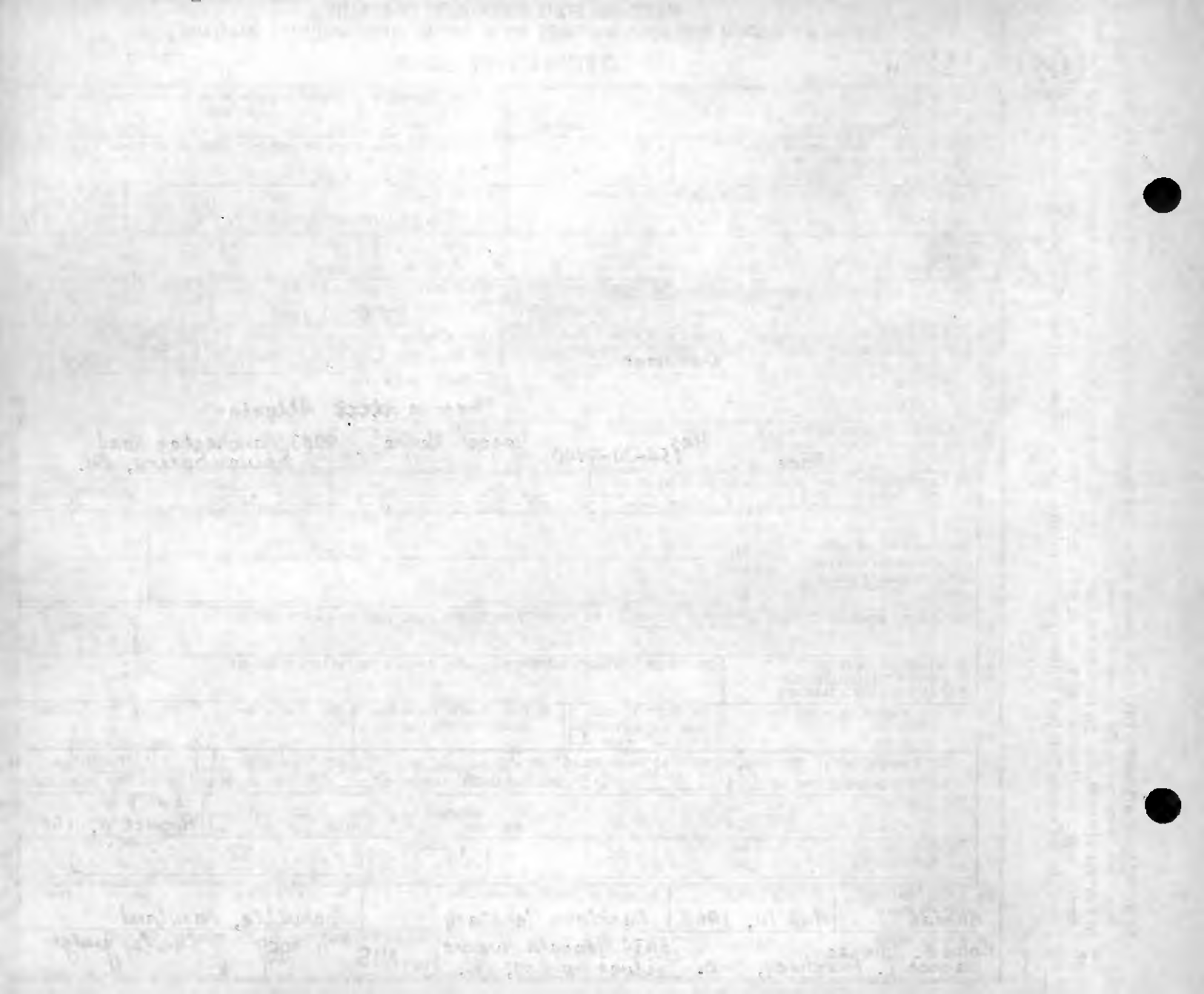
## CERTIFICATE OF DEATH

11281

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. &amp; Hosp.</u>		d. STREET ADDRESS <u>9063 Manchester Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Madeline</u> Middle <u>Eloise</u> Last <u>Renne</u>		4. DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-24-00</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Prof.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Leonard Scheidig</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Abbie Allgeier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>154-20-9440</u>	
17. INFORMANT <u>Joseph Renne</u>		Address <u>9063 Manchester Road, Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Ovary with metastases</u> 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 23</u> , 19 <u>67</u> to <u>Aug 7th</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Aug 7th</u> , 19 <u>67</u> , and that death occurred at <u>4:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Lytle Williams</u>		22b. DATE SIGNED <u>August 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lytle Williams</u>		22d. ADDRESS <u>831 University Blvd E Silver Spring</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 10, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>Warner E. Humphrey, Inc.</u>	
25b. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>		25c. DATE <u>AUG 9 1967</u>	





11281

## CERTIFICATE OF DEATH

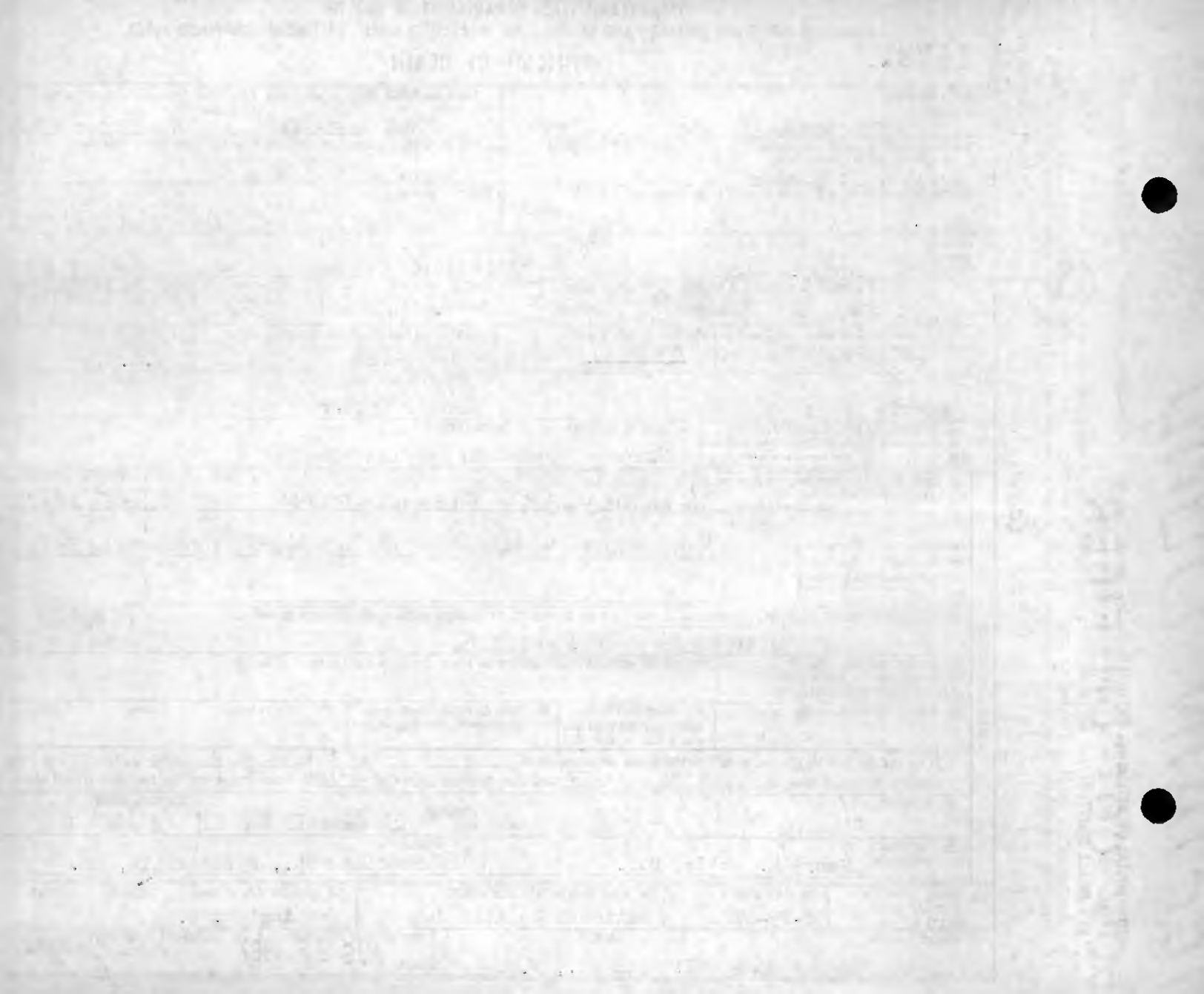
11282

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Examined - 6:30 pm 8/23/67

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>			d. STREET ADDRESS <u>11200 LOCKWOOD DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARCELLA N. RESNICK</u>			4. DATE OF DEATH Month Day Year <u>8 22 19 67</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUC</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29, 1904</u>	9. AGE (In years last birthday) yrs. <u>62</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Morris Jaffe</u>		
14. MOTHER'S MAIDEN NAME <u>Esther Netter</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>Unknown</u>			17. INFORMANT Address <u>Nathan Resnick Same as 2</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416X VENTRICULAR FIBRILLATION</u> DUE TO (b) <u>RHEUMATIC &amp; ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>40 YEARS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>25 MIN.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>DIABETES MELLITUS</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> , to <u>22 AUG</u> , 1967, that (I) (we) last saw the deceased alive on <u>22 AUG</u> , 1967, and that death occurred at <u>5:45 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Henry R. Wolfe</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry R. Wolfe, M.D.</u>		22d. ADDRESS <u>905 Sheridan St., Hyattsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-25-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Capital Hebrew</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Goldberg Funeral Home 4217 9th St., N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 25 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		





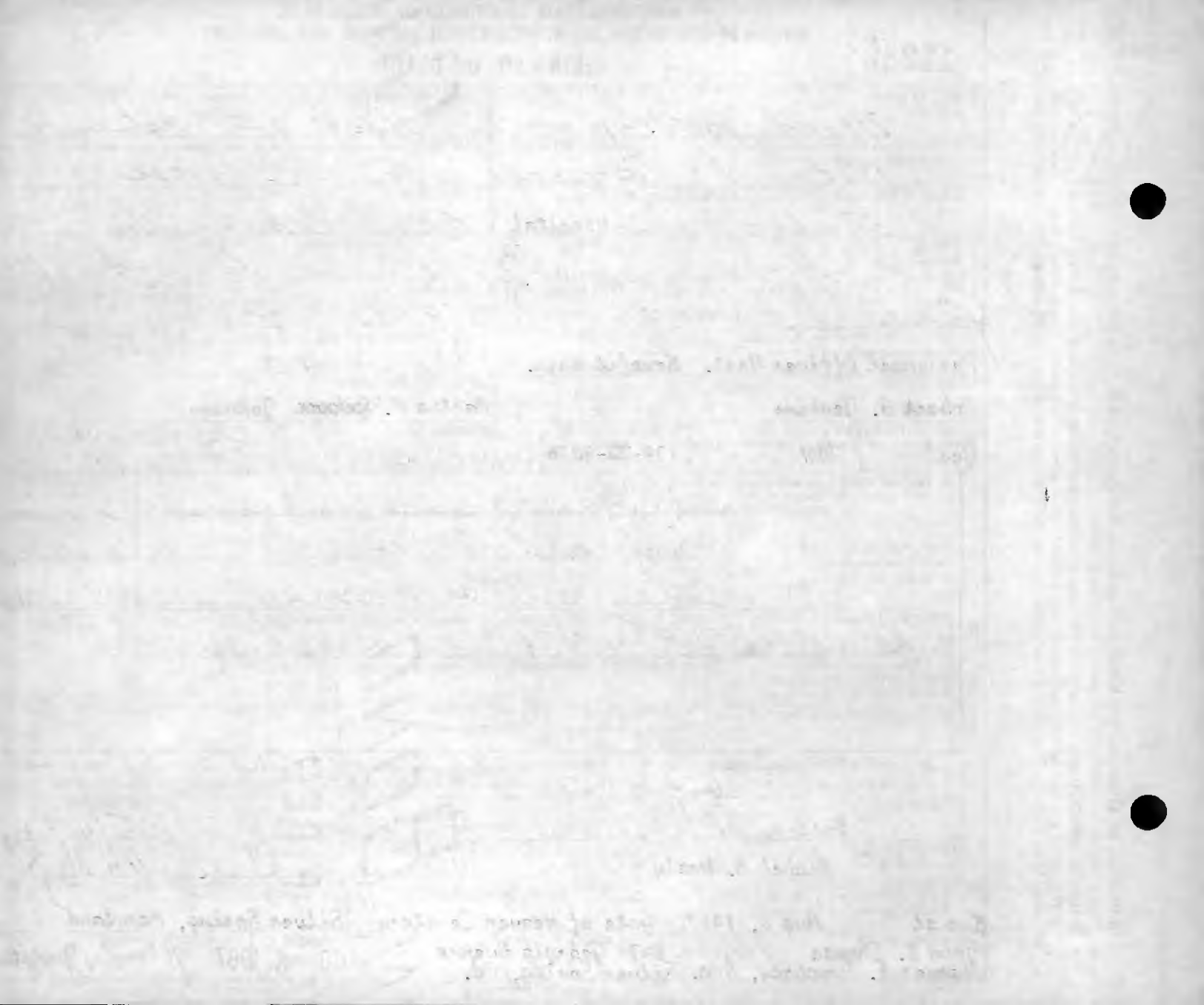
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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>154 days</u>		d. STREET ADDRESS <u>5420 - Columbia Ave NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Augusta</u> Last <u>Rich.</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/8/90</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Personnel Officer Asst.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Benefit Assn.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert A. Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Martha A. Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>139-22-9076</u>	
17. INFORMANT <u>Don Donald</u>		Address <u>303 Charlton Ct. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Intractable Congestive Heart failure</u> DUE TO (b) <u>Myocardial infarct</u> DUE TO (c) <u>Coronary Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>8 weeks</u> <u>sev. years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right ureteral lithiasis c Right Pyonephrosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>63</u> to <u>Aug 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug 4</u> 19 <u>67</u> , and that death occurred at <u>8:45</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Michel M. Healy</u>		22b. DATE SIGNED <u>8/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Michel M. Healy</u>		22d. ADDRESS <u>Washington Clinic, Washington</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>AUG 8 1967</u>	
25b. REGISTRAR'S SIGNATURE			



CERTIFICATE OF DEATH

11283

11283

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>26 days</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Dade</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Doral</u> d. STREET ADDRESS <u>3315 Calle Larga</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clifford B. Richardson</u> First Middle Last 4. DATE OF DEATH <u>Aug. 13 1967</u> Month Day Year				5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>2/9/1887</u> 8. AGE (In years last birthday) <u>80</u> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>S.D. South Dakota</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>George Richardson</u> 14. MOTHER'S MAIDEN NAME <u>Alice Bartlett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u> 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Alfred P. Richardson MD</u> Address <u>734 Maryland Rd Bethesda MD</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. CAUSE WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO (b) <u>MALIGNANT BLADDER TUMOR</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u> <u>2 YRS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 17, 1967</u> to <u>AUG 13, 1967</u> , that (I) (we) lost the deceased on <u>AUG 13, 1967</u> , and that death occurred at <u>3:20 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>DR. LEO I. DONOVAN</u> 22d. ADDRESS <u>8214 WILSON AVE BETHESDA MD</u> 22b. DATE SIGNED <u>8/13/67</u>							
23a. BURIAL, CREMATION, or other disposition <u>BURIAL</u>		23b. DATE THEREOF <u>8-16-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grandlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Detroit Mich</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>7557 Wilson Ave</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>AUG 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11285

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shawnee Hospital House - Rd.</u>		a. STREET ADDRESS <u>306 West Diamond Ave</u>	
3 NAME OF DECEASED (Type or print) <u>Roland</u> First <u>(none)</u> Middle <u>Ricketts</u> Last <u>SA</u>		4 DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 28, 1930</u> 9 AGE (In years, most birthday) <u>36</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>Ernest C Ricketts</u>		14 MOTHER'S MAIDEN NAME <u>Margaret Carter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>214-30-0832</u>	
17 INFORMANT <u>Dolores Ricketts - wife</u> Address <u>add. same</u>			
18 CAUSE OF DEATH (Enter only one cause per part. I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> DUE TO (b) <u>Shot gun - Wound -</u> DUE TO (c) <u>lost.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Shot in Right Arm with shot gun.</u>	
20c. TIME OF INJURY Month, Day, Year <u>1:45 PM 8/5 1967</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Potomac - Mont. Md.</u>
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>8/5/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>8/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	23d. LOCATION (City or Town) (County) (State) <u>Gaithersburg, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u> Address <u>Funeral Home-1331 Rockville Pike Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 9 1967</u> DATE	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11285

11288

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD.</u> b COUNTY <u>Mont. Co.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>2510 - Weissman Rd.</u>	
3 NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Rintheimer</u> Last <u>White</u>		4 DATE OF DEATH Month <u>Aug.</u> Day <u>20</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/3/194</u>
9 AGE (In years last birthday) <u>75</u> yrs		10 UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
11 BIRTHPLACE (Country & State, or foreign country) <u>Tex. 25</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Thaddeus C. Bell</u>		14. MOTHER'S MAIDEN NAME <u>Florence Whites</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>215-54-6009</u>	
17. INFORMANT <u>James B. Rintheimer</u>		Address <u>As above</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Advanced Coronary arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>two weeks</u> years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremic, arteriolar and arterial nephrosclerosis &amp; cerebral arteriosclerosis</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , 19 <u>Aug 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>20 Aug</u> 19 <u>67</u> , and that death occurred at <u>6:27</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>George Sharpe</u>		22b DATE SIGNED <u>8/21/67</u>	
22c PHYSICIAN'S NAME (Type) <u>George Sharpe</u>		22d. ADDRESS <u>10400 Conn. Avenue, Kensington, Md.</u>	
23a B.R.IAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d. LOCAT ON (City or Town) (County) (State)
<u>Cremation</u>	<u>Aug. 22, 1967</u>	<u>Fort Lincoln Crematory</u>	<u>Prince Georges County, Md.</u>
24 FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a REC'D BY REGISTRAR <u>Aug 24 1967</u>	
<u>Warner E. Humphrey</u>		<u>Charles Judge</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11286

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11287

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write to RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b. <u>20A</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>9720 Overlea Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARRIE ELIZABETH RITZ</u>				4. DATE OF DEATH Month Day Year <u>Aug. 29 1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 11 1894</u>	9. AGE (In years lost birthday) yrs <u>73</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Siegrist</u>				14. MOTHER'S MAIDEN NAME <u>Kensington</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>213-56-8709</u>		17. INFORMANT Address <u>Lois ELIZ. McCARY Kensington, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> 4a. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>Cardio-Vascular Disease</u> DUE TO (b) <u>Cardio-Vascular Disease</u> DUE TO (c) <u>Cardio-Vascular Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Adenocarcinoma of ovary with metastasis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>8-29 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/29/67</u>			
				Address (Street, city, town, or county) <u>Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-1-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>AUG 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



VR A15 (4)  
25M 1/67

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring, Md.</u>		c LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp</u>		d STREET ADDRESS <u>10601 Glenhaven Drive</u>	
3 NAME OF DECEASED (Type or print) <u>IRVING Francis Robey</u>		4 DATE OF DEATH <u>8 27 1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8/6/91</u>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer, retired</u>		9b KIND OF BUSINESS OR INDUSTRY <u>Grocer Self-employed</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer, retired</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Grocer Self-employed</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>Henry Robey</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Martin</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) <u>No</u>		16 SOCIAL SECURITY NO <u>578-46-8922A</u>	
17 INFORMANT <u>Ann M. Robey</u>		Address <u>Silver Spring, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion Acute</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>vertebral Coli, Urthral Structure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c TIME OF INJURY Month, Day, Year Hour o m. p m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May, 1963</u> to <u>Aug, 1967</u> that (I) <u>was</u> last saw the deceased alive on <u>16 Aug 1967</u> and that death occurred at <u>1320A</u> from causes and on the date stated above			
22a SIGNATURE <u>Thomas P. Fogarty</u> MD		22b DATE SIGNED <u>27 Aug 67</u>	
22c PHYSICIAN'S NAME (Type) <u>Thomas P. Fogarty</u>		22d ADDRESS <u>1011 Univ. Blvd E Silver Spring, Md</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Aug. 30, 1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Smithland, Maryland</u>	
24a FUNERAL DIRECTOR <u>John B. Thomas</u>		25a REC'D BY REGISTRAR <u>SEP 1 1967</u>	
24b FUNERAL HOME <u>Warner E. Purshrey Funeral Home Silver Spring</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11288

1289

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>26 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>106-A Ames Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie Laurie Robinson</u>				4 DATE OF DEATH Month Day Year <u>8 11 1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-15-03</u>	9. AGE (In years last birthday) <u>64</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Melvin Imlay</u>				14. MOTHER'S MAIDEN NAME <u>Margaret V. Money</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>578-20-7500</u>		17. INFORMANT <u>Records - Washington Sanitarium &amp; Hospital</u> Address			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>ASSOCIATED WITH ARRHYTHMIA</u> DUE TO (c) <u>HYPERTENSIVE CARDIOVASCULAR DIS.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>WEEKS</u> <u>TERMINAL</u> <u>YEARS</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>July 16, 1967</u> to <u>Aug 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 11, 1967</u> , and that death occurred at <u>1:15 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Boris Rabkin</u>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>Aug 11, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN, M.D.</u>		22d. ADDRESS <u>10109 Univ Blvd, EGM</u>					
23a. BURIAL, CREMATION, or MOVIAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-14-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md</u>			
24. FUNERAL DIRECTOR <u>Mr. Theodore Lane</u>		ADDRESS <u>Washington D.C.</u>		25a. REC'D BY REGISTRAR <u>AUG 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

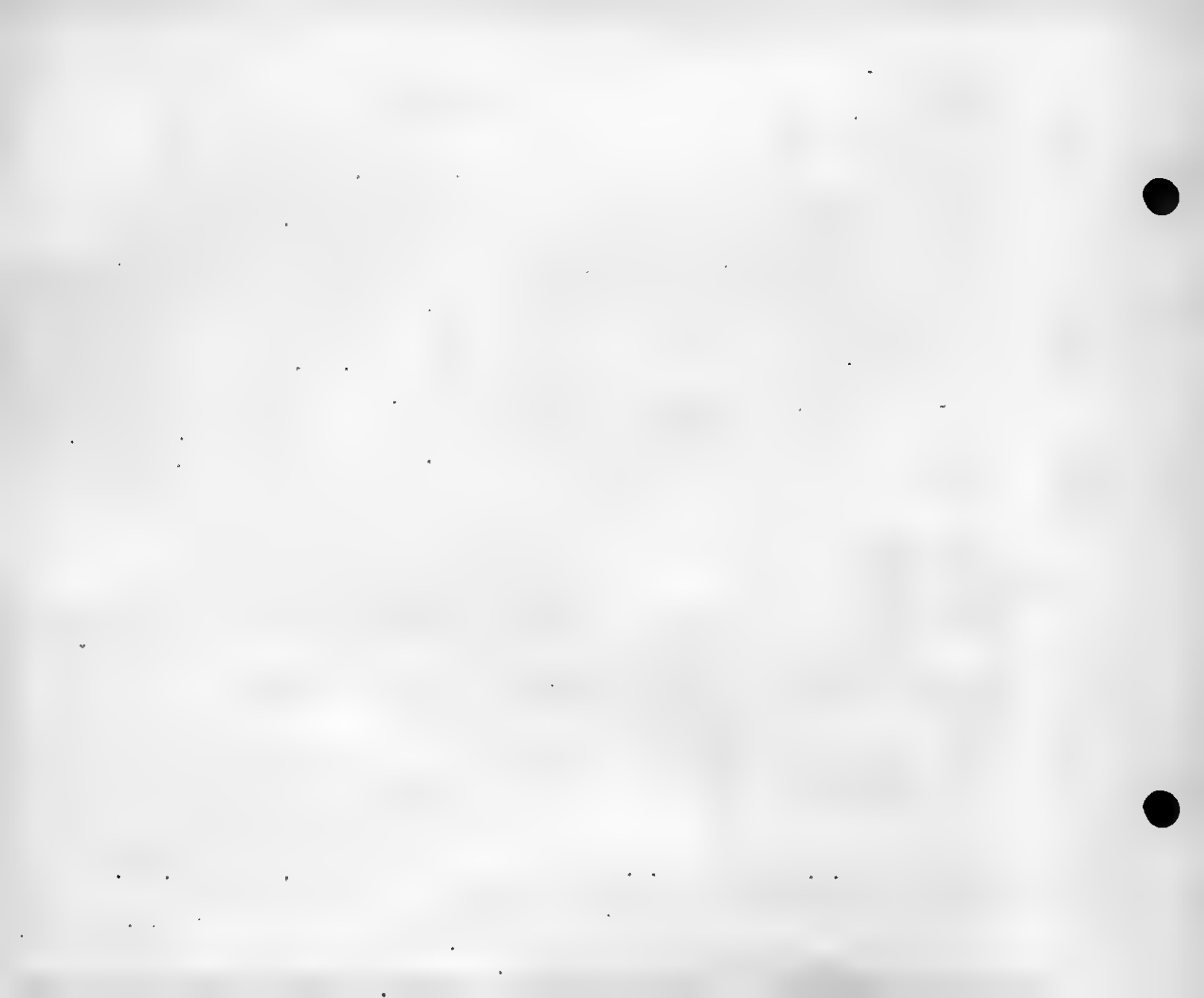
VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

11289

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	c. LENGTH OF STAY IN lb <b>69 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>7203 Woodrow Ave.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <b>John Frederick RODENBERG</b> First Middle Last		4. DATE OF DEATH Month <b>8</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 April 1946</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Military</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USMC</b>	9. AGE (In years last birthday) yrs. <b>21</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Frederick Rodenberg</b>		14. MOTHER'S MAIDEN NAME <b>Julia Mary Dorn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes Viet Nam</b>		16. SOCIAL SECURITY NO. <b>216 48 0083</b>	
17. INFORMANT <b>XXXX3 Newburn Court.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration brain, Fractured skull</b> <b>445 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Shrapnel wound</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hit by hostile fire, while under attack</b>		20c. TIME OF INJURY Month, Day, Year <b>1300 hour 5 19 19 67</b>	
20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Viet Nam</b>	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>2 June</b> , 19 <b>67</b> , to <b>11 August</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11 August</b> 19 <b>67</b> , and that death occurred on <b>0305A</b> AM, from causes and on the date stated above.	
22a. SIGNATURE <b>R. B. Moquin (O.O.O.)</b>		22b. DATE SIGNED <b>11 August 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. B. MOQUIN</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City or Town) (County) (State) <b>5501 Frederick Ave. Baltimore Md</b>
24. FUNERAL DIRECTOR <b>Dinner Funeral Home Inc. 7110 Belair Rd.</b>		25a. REC'D BY REGISTRAR <b>AUG 16 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11281

1. PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Silver Spring, Md.</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>		c LENGTH OF STAY IN 1b <u>3d.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp.</u>		d STREET ADDRESS <u>1500 - Forest Glen Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Bella</u> First <u>Rosenblatt</u> Middle <u>Rose</u> Last		4. DATE OF DEATH <u>8 - 17</u> 19 <u>67</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/9/94</u> 9. AGE (In years lost birthday) <u>73</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Lith.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Maximillian Israel</u>		14. MOTHER'S MAIDEN NAME <u>Rose ---</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Daughter</u> Address <u>Ms - Lou Rubin</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia (renal failure)</u> DUE TO (b) <u>Arteriosclerotic Nephrosclerosis</u> stating the underlying cause last. (c) <u>Chronic lymphocytic Leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic lymphocytic Leukemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (name, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>66</u> , to <u>Aug. 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug. 16</u> 19 <u>67</u> , and that death occurred at <u>4:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Gene U. Cohen M.D.</u>		22b. DATE SIGNED <u>Aug 17, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>GENE U. COHEN, M.D.</u>		22d. ADDRESS <u>1106 SPRING ST SILVER SPRING MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Douglas Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>W. Roxbury, Mass.</u>
24. FUNERAL DIRECTOR <u>B. Wanzanovsky &amp; Sons</u>		25a. REC'D BY REGISTRAR <u>AUG 21 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





Cleared with Medical Examiner

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN 1b <b>WASHINGTON</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON SAN. &amp; HOSP.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DC</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> d. STREET ADDRESS <b>608 Van Buren St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>CATHERINE ELIZABETH RUDDY</b>			First <b>CATHERINE</b>		Middle <b>ELIZABETH</b>		Last <b>RUDDY</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>22</b> Year <b>1967</b>		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 7, 1888</b>		9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>IRELAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>JAMES KEADY</b>					14. MOTHER'S MAIDEN NAME <b>SARAH MCDONOUGH</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NONE</b>			16. SOCIAL SECURITY NO. <b>579-10-3820</b>		17. INFORMANT Address <b>HOSPITAL RECORDS</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>Indefinite</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 7, 1966</b> to <b>Aug. 22, 1967</b> that (I) (we) last saw the deceased alive on <b>Aug. 22, 1967</b> and that death occurred at <b>6:30 AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>A. B. Little</b>					22b. DATE SIGNED <b>SEP 1 1967</b>						
22c. PHYSICIAN'S NAME (Type) <b>A. B. LITTLE, M.D.</b>					22d. ADDRESS <b>6911 5th St NW Wash. DC</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>8-26-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>			23d. LOCATION (City, town or county) (State) <b>WASH. D.C.</b>			
24. FUNERAL DIRECTOR <b>HANLON FUNERAL HOME - WASH. D.C.</b>					25a. REC'D BY REGISTRAR <b>SEP 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				



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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11293

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>8 1/2 mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1. ALTHEA WOODLAND NURSING HOME</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WASHINGTON D.C.</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>3133 Conn. Ave. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANTOINETTE M. RUDOLPH</b>		4. DATE OF DEATH Month Day Year <b>Aug 31 1967</b>	
5. SEX <b>fe</b>	6. COLOR OR RACE <b>Coac</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3-1886</b>
9. AGE (in years last birthday) <b>81 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Mins. <b>81</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Federal Employee</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>South Dakota</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Arthur F. Rudolph</b>	
14. MOTHER'S MAIDEN NAME <b>Matilda Pauline Babbe</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Edward S. Rudolph</b> Address <b>9036 1st Pl. Capitol Heights Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer, metastasis</b> 170x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Cancer heart</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>none</b>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	
20f. (City or town) (County) (State) <b>none</b>		21. I certify that (I) (this hospital) attended the deceased from <b>June 1967</b> to <b>31 Aug. 1967</b> , that (I) (we) last saw the deceased alive on <b>26 Aug. 1967</b> , and that death occurred at <b>6:10 M.</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>A. H. RICHWINE, M.D.</b>		22b. DATE SIGNED <b>3 Aug 1967</b>	
22c. PHYSICIAN'S NAME (Type or print) <b>A. H. RICHWINE, M.D.</b>		22d. ADDRESS <b>5522 WESTERN AVE CHEVY CHASE MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>9/5/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>The H. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>2901 14th St. N.W.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>SEP 5 1967</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11293

## CERTIFICATE OF DEATH

11294

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>27 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cornelia Villa Nursing Home</u>		d. STREET ADDRESS <u>706 Whittier N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Ida</u> First <u>P.</u> Middle <u>St. George</u> Last <u></u>		4. DATE OF DEATH <u>8/6/67</u> Month <u>8</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-31-1876</u>
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>218-20-1442-D</u>	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> DUE TO <u>Cor. Fibillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>8/4/67</u> <u>8/4/67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>3/22/37</u> Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/22/37</u> , 19 <u>37</u> to <u>8/6/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/5/67</u> , 19 <u>67</u> , and that death occurred at <u>11:15</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Edward I. Morse</u> M.D.		22b. DATE SIGNED <u>8/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward I. Morse</u>		22d. ADDRESS <u>7036 Carroll Lane Takoma Park Md</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/9/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>J. Walter Walters</u>		25a. REC'D BY REGISTRAR <u>WJG</u> DATE <u>10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Walter Walters</u>		25c. REGISTRAR'S SIGNATURE <u>J. Walter Walters</u>	



11294

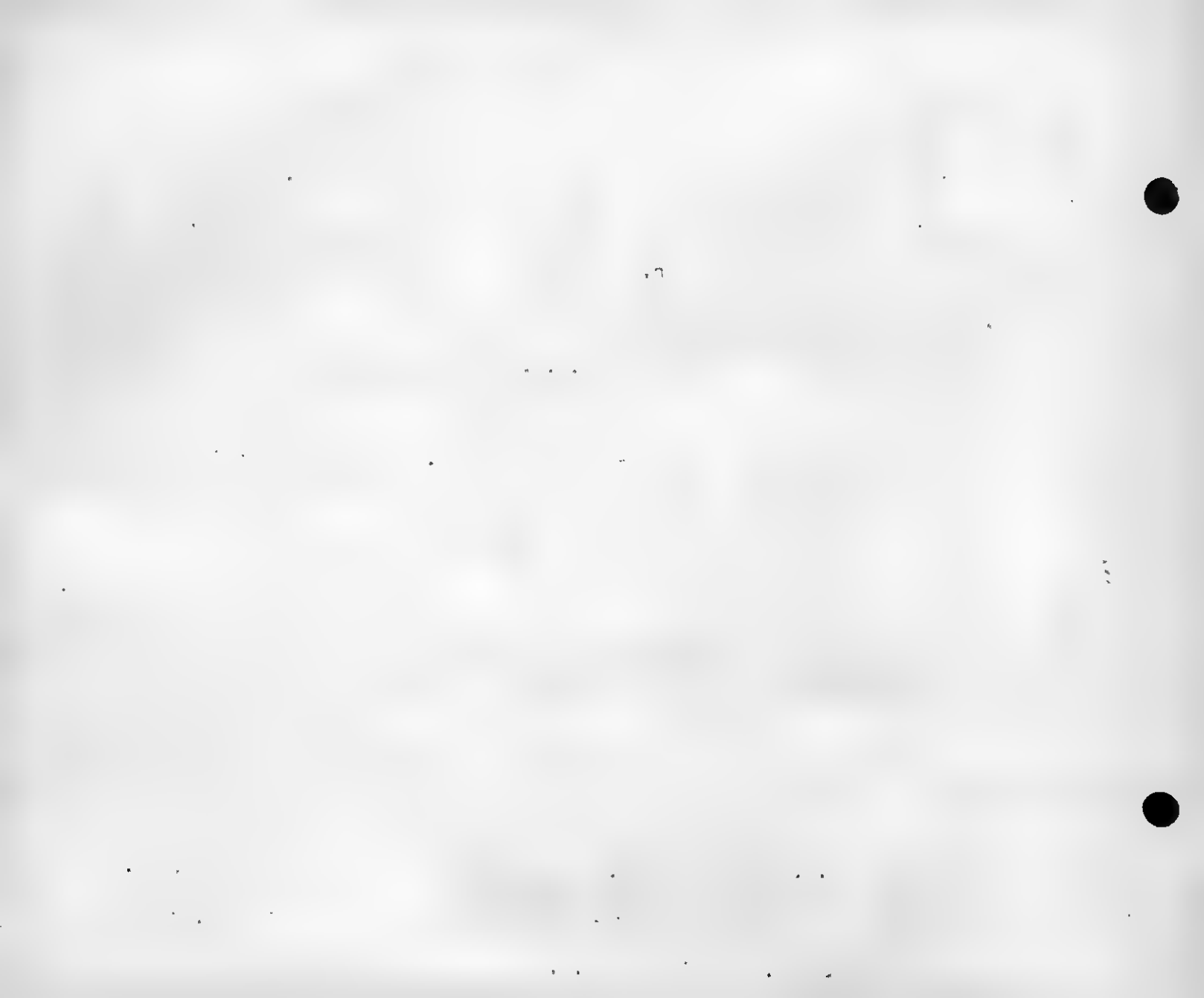
## CERTIFICATE OF DEATH

11295

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>4 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>3923 Livingston Rd.</b>	
3 NAME OF DECEASED (Type or print) <b>Robert S. SANCHEZ</b>		4. DATE OF DEATH Month <b>8</b> Day <b>14</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-8-95</b>
9. AGE (In years last birthday) yrs. <b>72</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Military</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.N.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Phillipine Islands</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO <b>577-12-7929</b>	
17. INFORMANT <b>Laura V. SANCHEZ, Hyattsville, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>10 August, 1967</b> to <b>14 August, 1967</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>14 August 1967</b> , and that death occurred on <b>11 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>P.T. Kirchner</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>P.T. Kirchner M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/18/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>Lee's Funeral Home</b> <b>4th &amp; Mass. Ave., Washington, D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 16 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1-286											
1. PLACE OF DEATH a. COUNTY <u>Montgomery Co - Silver Spring</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>571 University Blvd E. S.S. Md</u>						d. STREET ADDRESS <u>8401 Flower Ave.</u>					
3. NAME OF DECEASED (Type or print) <u>Letteria First Pestane Middle Sapienza Last</u>						4. DATE OF DEATH <u>Aug 13 1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4 1879</u>		9. AGE (in years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				11b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Italy.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>UNKNOWN</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-68-0734</u>		17. INFORMANT <u>Mrs. Joseph Benvenuto</u>			Address <u>903 Mari Bude Sil Sp Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>C.V.A.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-vascular Renal Disease</u> DUE TO (c) <u>Cardio-vascular Renal Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u> <u>2 Wks</u> <u>2 Yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>67</u> to <u>AUG 13 1967</u> , that (I) (we) last saw the deceased alive on <u>AUG 12 1967</u> , and that death occurred at <u>7:30</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Harold Heiges MD</u>						22b. DATE SIGNED <u>Aug 15 1967</u>					
22c. PHYSICIAN'S NAME (Type) <u>Harold Heiges MD</u>						22d. ADDRESS <u>1835 Eye St NW</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<u>BURIAL</u>		<u>17 AUG 1967</u>		<u>ST. MARY'S CEMETERY</u>		<u>WASHINGTON DC.</u>					
24. FUNERAL DIRECTOR <u>PINARDI FUNERAL HOME INC. 7400 Georgia Ave. N.W. DC</u>						25a. REC'D BY REGISTRAR <u>20012</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			

MEDICAL CERTIFICATION



11296

## CERTIFICATE OF DEATH

11297

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1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>MONTGOMERY</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c LENGTH OF STAY IN 1b <u>DOM</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>				d STREET ADDRESS <u>7211 MAPLE AVE.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>HUGH</u> Middle <u>H.</u> Last <u>SAUM, SR</u>				4 DATE OF DEATH Month <u>Aug</u> Day <u>11</u> Year <u>1967</u>			
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JUNE 3, 1889</u>	9 AGE (In years last birthday) <u>78</u> yrs.	11 IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		12 IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>Hugh Harris Saum</u>				14. MOTHER'S MAIDEN NAME <u>Ernestine A. Queensbury</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>578-01-1336</u>		17 INFORMANT Address <u>Wash. D.C.</u> <u>Robert W. Saum-4010 Veazey St NW</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> <u>+ DVI</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease - coronary insufficiency and old myocardial infarction</u> (c) <u>  </u>							INTERVA. BETWEEN ONSET AND DEATH <u>since 1938</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1954 (open)</u> 19 <u>  </u> , to <u>8/11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/25</u> 19 <u>67</u> , and that death occurred at <u>11:30 A.M.</u> from causes and on the date stated above							
22a. SIGNATURE <u>William C Bailey Jr</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED <u>8/11/67</u>	
22c PHYSICIAN'S NAME (Type) <u>William C Bailey, Jr</u>				22d ADDRESS <u>1835 Eye St NW</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-15-1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.</u>				25a. RECD BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>  </u>			



## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Potomac</b>		c. LENGTH OF STAY IN It <b>Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9721 Corral Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDITH GRAHAM SCHILLING</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>6</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 18, 1893</b>
9. AGE (In years lost birthday) <b>73</b> YES		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Downes Grove, Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edmund H. Graham</b>		14. MOTHER'S MAIDEN NAME <b>Mary Shaw</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Walter Schilling, Same as #1</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronoma Liller</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS A. TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-15</b> , 1966, to <b>8-6</b> , 1967 that (I) (we) last saw the deceased alive on <b>8-5</b> , 1967, and that death occurred at <b>5:11</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Theo. R. Coleman</b> M.D.		22b. DATE SIGNED <b>8-6-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. THEO. R. COLEMAN</b>		22d. ADDRESS <b>1835 Fyfe St NW Wash. DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/8/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons,</b>		25. REC'D BY REGISTRAR <b>Aug 8 1967</b>	
5130 Wisconsin Ave, NW Washington, D.C.		25b. REGISTERED SIGNATURE <b>John H. Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11298

CERTIFICATE OF DEATH

11299

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>30 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattstown</b>		12/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Henry</b> Last <b>Schrayer</b>		4 DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12-2-97</b>
9. AGE (In years lost birthday) <b>69</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>	11 BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Jacob Schrayer</b>		14. MOTHER'S MAIDEN NAME <b>Emma Heckman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO <b>203-01-9067</b>	
17. INFORMANT <b>Medical Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Right LOBAR PNEUMONIA</b> (c) <b>CORONARY SCLEROSIS OR III</b>			INTERVAL BETWEEN ONSET AND DEATH <b>TEEN WRS YRS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CIRRHOSIS LIVER: PYELONEPHRITIS: MESENTERIC OCCLUSION</b>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>7/17</b> , 19 <b>67</b> , to <b>8/16</b> , 19 <b>67</b> , that (II) (we) last saw the deceased alive on <b>8/15</b> , 19 <b>67</b> , and that death occurred at <b>8 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Donald R. Lewis</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <b>8/16/67</b>
22c. PHYSICIAN'S NAME (Type) <b>DONALD R. LEWIS</b>		22d. ADDRESS <b>OLNEY, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8-22-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Seals Cemetery, Cam.</b>	23d. LOCATION (City or town) (County) (State) <b>Etchison, Maryland</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 28 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11299

CERTIFICATE OF DEATH

11300

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>15 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase 141</u> d. STREET ADDRESS <u>8410 Donneybrook Dr</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Eleanor</u> Last <u>Schein</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-22-1922</u> 9. AGE (In years last birthday) yrs. <u>45</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marty Co. School Bldg</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas E. Hardesty</u>		14. MOTHER'S MAIDEN NAME <u>Ruth E. Elms</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-16-2084</u>	
17. INFORMANT <u>Mother - Ruth Hardesty</u> Address <u>706 Littleton St. Silver Spring</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1939</u> DUE TO <u>Cerebral Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Status post Craniotomy</u> (c) <u>Astrocytoma grade III</u>		INTERVAL BETWEEN DEATH AND DEATH <u>7 da</u> <u>3-4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-16</u> , 19 <u>67</u> to <u>8-30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-30</u> , 19 <u>67</u> , and that death occurred at <u>11:45</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Jonathan M. Williams</u>		22b. DATE SIGNED <u>8-31-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jonathan M. Williams</u>		22d. ADDRESS <u>808 Pershing Dr. Silver Spring</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Warner E. Humphrey Funeral Home</u>		25a. REC'D BY REGISTRAR <u>10 SEP 5 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Juanita Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 3 event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11301

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> 151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac Valley Nursing Home</b>		d. STREET ADDRESS <b>9 Nelson Street</b>	
3 NAME OF DECEASED (Type or print) <b>ELLEN BREDELL SCHUMACHER</b>		4 DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 12, 1894</b>
9. AGE (In years last birthday) <b>73</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proof-reader-Newspaper - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>North Dakota</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>North Dakota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Henry O. Bredell</b>		14. MOTHER'S MAIDEN NAME <b>Anna Hansen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO	
17. INFORMANT <b>Daughter Carol A. Shanahan</b>		Address <b>Same as Item 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>broncho pneumonia</b> DUE TO <b>stroke</b> (b) <b>stroke</b> DUE TO <b>stroke</b> (c) <b>cerebral vascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2-4 hrs</b> <b>4 hrs</b> <b>years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerotic heart disease &amp; rheumatoid arthritis</b>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11/9, 1965</b> to <b>8/21, 1967</b> that (I) (we) last saw the deceased alive on <b>8/9, 1967</b> , and that death occurred at <b>4:40 PM</b> , from causes and on the date stated above.			
22. SIGNATURE <b>G. Bowditch Hunter, Jr.</b> M.D.		22d DATE SIGNED <b>8/24/67</b>	
22c PHYSICIAN'S NAME (Type) <b>G. Bowditch Hunter, Jr.</b>		22d ADDRESS <b>50 W. Edmonston Drive Rockville, Maryland</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b DATE THEREOF <b>8-28-67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	23d LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a REC'D BY REGISTRAR <b>AUG 25 1967</b>	
		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11302

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>NEW JERSEY</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>		c. LENGTH OF STAY IN 1b <b>6 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac Valley Nursing Home</b>		d. STREET ADDRESS <b>36 Hampton St and Potomac Valley Rd Rockville Md</b>	
3 NAME OF DECEASED (Type or print) <b>MADEL</b> First Middle Last		4. DATE OF DEATH Month <b>AUG</b> Day <b>16</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-8-89</b>
9. AGE (In years last birthday) <b>82</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COUNTY GOVT</b>	
11. BIRTHPLACE (County & State or foreign country) <b>NEW YORK, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>WILLIAM STILWELL</b>		14. MOTHER'S MAIDEN NAME <b>LILLIAN DAVIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>138-30-6153</b>	
17. INFORMANT <b>HOSP. RECORD</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA, LUNG RT</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>METASTASES TO BONES</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-29, 1967</b> to <b>8-16, 1967</b> , that (I) (we) last saw the deceased alive on <b>AUG 16 1967</b> and that death occurred at <b>1:25 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Leo M. Curtis</b>		22b. DATE SIGNED <b>8-16-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>LEO. M. CURTIS</b>		22d. ADDRESS <b>6248 WISC. AVE. BETHESDA, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>8-16-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) <b>Metuchen N.J.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		25. REC'D BY REGISTRAR <b>CHARLES JUDGE</b>	
25. ADDRESS <b>5130 Wisc. Ave. N.W. Wash. D.C.</b>		DATE <b>AUG 21 1967</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

11302

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22803

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4621 Morgan Drive</u>	
3 NAME OF DECEASED (Type or print) <u>Margaret L. Shank</u>		4. DATE OF DEATH <u>8-6-67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>GR</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-14-1899</u>
	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years (as of birthday) yrs) <u>68</u>	10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
13. FATHER'S NAME <u>William L. Cate</u>		14. MOTHER'S MAIDEN NAME <u>Nora Ellis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Husband - Oscar E. Cate</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <u>1201</u> IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Posterior</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>---</u>			INTERVAL BETWEEN DEATH AND EXAMINATION <u>12 HOURS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>---</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion a death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.		22. DATE SIGNED <u>8/6/67</u>	
EXAMINER'S NAME (Type) <u>John S. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-9-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>8130 Wisc. Ave. N.W. Wash. DC.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 3 1967</u>			





11304

11303

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>15-1</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>	
3. NAME OF DECEASED (Type or print) <b>GRACE O. SHERTZER</b>		4. DATE OF DEATH Month <b>August</b> Day <b>20</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 23, 1887</b>
9. AGE (In years last birthday) <b>79</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>27</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Thomas Payne</b>		14. MOTHER'S MAIDEN NAME <b>Mary Virginia Claggett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-03-0165-D</b>	
17. INFORMANT <b>Beverly G. Morgan-Item # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> DUE TO (b) <b>Cerebro-vascular thrombosis</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>1 month</b> <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cirrhosis of Liver</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1967</b> to <b>Aug 20, 1967</b> , that (I) (we) last saw the deceased alive on <b>Aug 19, 1967</b> , and that death occurred at <b>8/20/67</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Richard A. Yates</b>		22b. DATE SIGNED <b>8/20/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard A. Yates</b>		22d. ADDRESS <b>17141 Old Balt. Rd., Olney, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/22/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1351 Rockville Pike Rockville, Maryland</b>		25a. RECD BY REGISTRAR DATE <b>AUG 22 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and a copy event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11304

11305

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Hall Sanitarium</b>				d. STREET ADDRESS <b>4715 Rosedale Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Florence Elizabeth Shoemaker</b> First Middle Last				4. DATE OF DEATH Month <b>Aug.</b> Day <b>4</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-20-84</b>	9. AGE (In years birthday) <b>82</b> yrs	10. IF UNDER 1 YEAR Months Days Hours Mm.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Food Mgr.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Montgomery</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Amos W. Magruder</b>				14. MOTHER'S MAIDEN NAME <b>Mollie Wilson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-18-4492</b>		17. INFORMANT <b>Carroll W. Shoemaker</b>		Address <b>7500 17th. Ave. Adelphi, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1</b> , 19 <b>67</b> , to <b>Aug 4</b> , 19 <b>67</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Aug 3</b> , 19 <b>67</b> , and that death occurred at <b>9:30 A.M.</b> from causes and on the date stated above							
22a. SIGNATURE <b>John D. Herman</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>Aug. 4, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. HERMAN</b>				22d. ADDRESS <b>4801 Montgomery Lane Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-7-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bethesda, Maryland</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>AUG 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



11305

## CERTIFICATE OF DEATH

11306

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		c. LENGTH OF STAY IN lb <u>2 1/2 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		d. STREET ADDRESS <u>7620 Maple Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Shoemaker, Frank W.</u>		4. DATE OF DEATH <u>August 22, 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19, 1908</u>
9. AGE (In years last birthday) <u>59</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CIT. ZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frank W. Shoemaker</u>		14. MOTHER'S MAIDEN NAME <u>Frances McCoy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO <u>577-10-3678</u>	
17. INFORMANT <u>Ruby A. Shoemaker</u>		Address <u>7620 Maple Avenue</u> <u>Jakoma Park, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>years</u> <u>years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> to <u>8-22-1967</u> , that (I) (we) last saw the deceased alive on <u>8-22-1967</u> and that death occurred at <u>10:00 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Kenneth Cruze</u>		22b. DATE SIGNED <u>Aug. 23, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Kenneth Cruze</u>		22d. ADDRESS <u>831 University Blvd. East, Maryland</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 25, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Virginia</u>	
24. FUNERAL DIRECTOR <u>John S. Thomas</u> <u>Walter E. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>AUG 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11306  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
Item 2 Film G393 9/29/67  
11307  
STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>15810 Bradford Rd.</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>15810 Bradford Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bradford Rest Home</u>				e. STREET ADDRESS <u>Silver Springs, Md.</u>			
3. NAME OF DECEASED (Type or print) <u>Sarah S. SHORT</u>				f. DATE OF DEATH <u>8 25 1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-6-1887</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Slye</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <input type="checkbox"/>			
17. INFORMANT <u>Record - Bradford Rest Home</u>				Address			
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerosis</u> DUE TO <u>Chronic Bronchitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-15</u> 19 <u>66</u> to <u>8-25</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11-30</u> 19 <u>67</u> and that death occurred at <u>8-25</u> 19 <u>67</u> at <u>11:30 P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Oliver J. Jackson, M.D.</u>				22b. DATE SIGNED <u>8-25-67</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>202 Martin La. Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>BURIAL</u>		<u>8/29/67</u>		<u>Holy Ghost Cemetery</u>		<u>Issue, Charles, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George R. Snowden</u>				25a. REC'D BY REGISTRAR <u>SEP 1 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11307

11308

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bessmer Sanitarium</u>		d. STREET ADDRESS <u>8820 Hawkins Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Maggie</u> First Middle Last <u>Simms</u>		4. DATE OF DEATH <u>8/19</u> Month Day Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/91</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Ida Conrad</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pul. Edema</u>			
DUE TO (b) <u>Cong. 2<sup>nd</sup> Failure</u>			
DUE TO (c) <u>Atherosclerotic C.V. Dis.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Overweight &amp; arterial hypertension</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/5</u> , 19 <u>66</u> to <u>8/19</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/19</u> , 19 <u>67</u> and that death occurred at <u>2:00 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Charles Judge</u>		22b. DATE SIGNED <u>8/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles Judge</u>		22d. ADDRESS <u>Rockville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/23/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lindbergh PARK</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville Montg. MD</u>
24. FUNERAL DIRECTOR <u>Wm R. Browder</u>		25a. REC'D BY REGISTRAR <u>Rockville</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>Aug 24 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove for burial papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #2a,b,c & d Film #G393 10/23/67 ph & Item #7											
11303 CERTIFICATE OF DEATH 11310											
1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Florida Pa.</b> b. COUNTY <b>Adams</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY in 1b <b>54 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nokomis Gettysburg</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>US NAVAL</b>						d. STREET ADDRESS <b>203 Hanover St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>RALPH</b> First <b>WALDO</b> Middle <b>SITLER</b> Last						4. DATE OF DEATH <b>AUG</b> Month <b>22</b> Day Year <b>67</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUC</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC 21 1907</b>		9. AGE (In years last birthday) yrs. <b>59</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Former State Dept.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Berwick, Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph H. Sitler</b>						14. MOTHER'S MAIDEN NAME <b>Lizzie Knorr</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes</b>				16. SOCIAL SECURITY NO <b>176 07 8339</b>		17. INFORMANT <b>Berwick, Pennsylvania</b> <b>Mrs. Esther M. Seely, 631 East 10th Street</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma Bladder</b> <b>1810</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>JUNE 29</b> , 19 <b>67</b> , to <b>AUG 22</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>AUG 22</b> , 19 <b>67</b> , and that death occurred at <b>4 P</b> M, from causes and on the date stated above											
22a. SIGNATURE <i>[Signature]</i>						M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>23 August 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>H. Rivas, M. D.</b>						22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/26/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>				23d. LOCATION (City or town) (County) (State) <b>Gettysburg, Pennsylvania</b>			
24. FUNERAL DIRECTOR <b>Monahan Funeral Home</b> <b>Gettysburg, Pennsylvania</b>						25a. REC'D BY REG. STRAR <b>Gettysburg Pa</b> DATE <b>AUG 28 1967</b>		25b. REG. STRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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25M 1/67

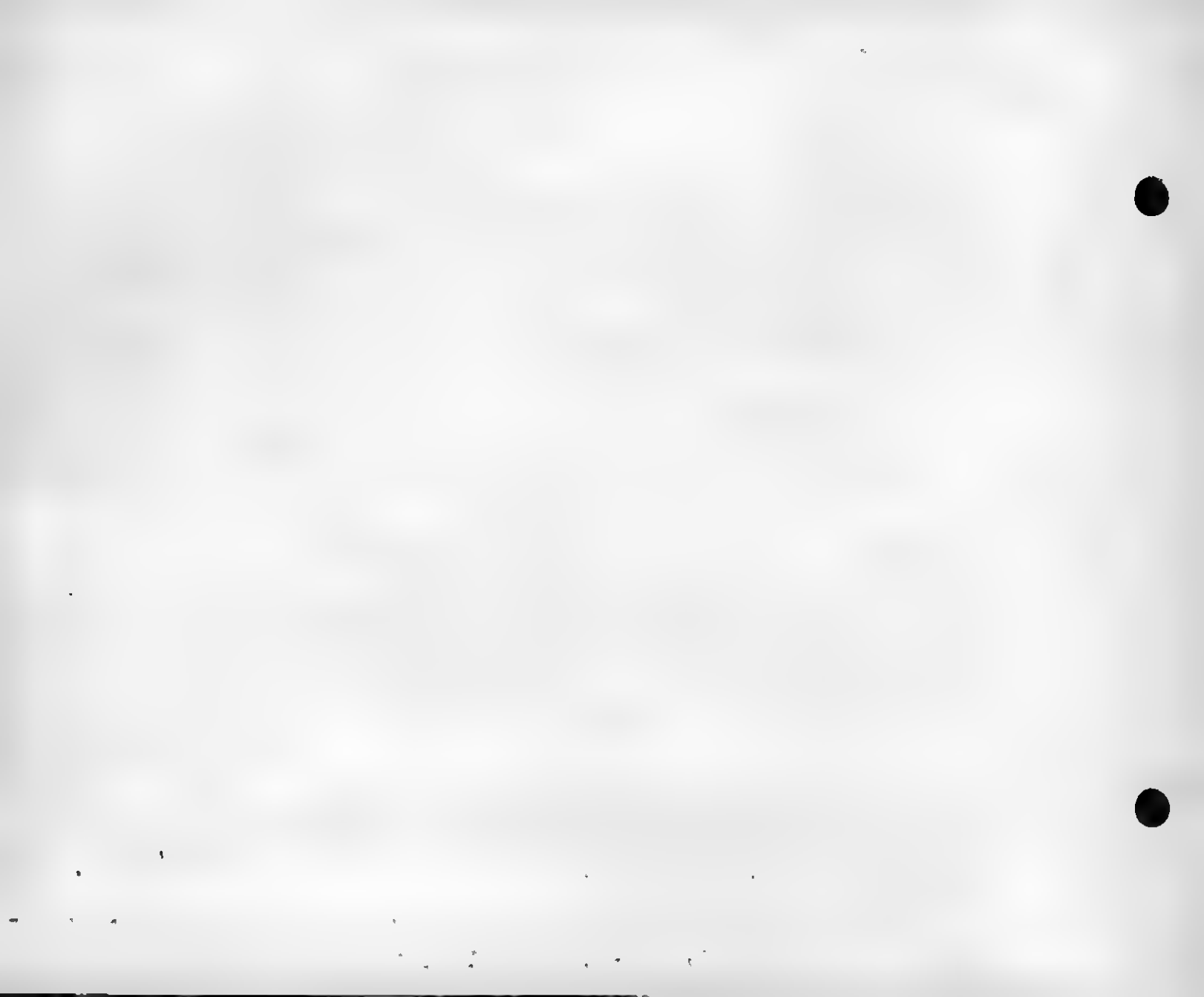
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11309

CERTIFICATE OF DEATH

11309

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>36 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>3814 Moravia Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>Regina</u> Last <u>Simpson</u>		4. DATE OF DEATH Month <u>August</u> Day <u>22</u> Year <u>19 67</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>21 July 1917</u>
9. AGE (In years last birthday) <u>50</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Taylor Tracey</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Amelia/Pfaff</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>220-14-6108</u>	
17 INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda, Maryland 20014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral embolus</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Atrial thrombosis &amp; calcification</u> DUE TO (c) <u>Rheumatic Heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>  <u>40 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <u>July 17</u> , 19 <u>67</u> , to <u>August 22</u> 19 <u>67</u> , that (X) (we) last saw the deceased alive on <u>August 22</u> , 19 <u>67</u> , and that death occurred at <u>3:30 M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Lynn M. Peterson</u>		22b. DATE SIGNED <u>22 August 1967</u>	22c. PHYSICIAN'S NAME (Type) <u>Lynn M. Peterson, MD.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal - Burial</u>		23b. DATE THEREOF <u>8-23-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pulasky Valley Mem. Gardens</u>
23d. LOCATION (City or Town) (County) (State) <u>Timonium, Balto. Co., Md.</u>		23e. REC'D BY REGISTRAR <u>Joseph Gawler's Sons, Inc.</u>	
24 FUNERAL DIRECTOR'S NAME (Type) <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Wisc. Ave. N.W. Wash. DC</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 24 1967</u>	



14  
1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

113.0  
11311  
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>9 da</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>4541 Windsor Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bruce (N) Smeed</u>		4. DATE OF DEATH Month Day Year <u>Aug 9 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/13/73</u>
9. AGE (In years, most birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Sp. Q.L.C.</u>	
13. BIRTHPLACE (County & State or foreign country) <u>Ohio</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>Edwin Smeed</u>		16. MOTHER'S MAIDEN NAME <u>Nancy Stevenson</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		18. SOCIAL SECURITY NO. <u>351-10-3340</u>	
19. INFORMANT <u>Hosp. Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>bronchogenic carcinoma left lung</u> DUE TO (b) <u>about 9 months</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>emphysema, severe, of lungs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
21a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	21b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	21c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21d. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/1</u> , 19 <u>67</u> , to <u>8/8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/8</u> , 19 <u>67</u> , and that death occurred at <u>3:55 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Philip Bloemsma</u>		22b. DATE SIGNED <u>8-9-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>PHILIP BLOEMSMA</u>		22d. ADDRESS <u>7701 Conn. Ave. Chevy Chase, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment</u>	23b. DATE THEREOF <u>Aug. 9, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Univ.</u>	23d. LOCATION (City or town) (County) (State) <u>Washington, DC</u>
24. FUNERAL DIRECTOR <u>Robert A. Hargrave 2552 Wisconsin Ave.</u>		25a. REC'D BY REGISTRAR <u>AUG 11 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





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VR A15 (4)  
25M 1/67

<div style="display: flex; justify-content: space-between;"> <span>11311</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>11312</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>											
1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Florida b. COUNTY Okaloosa					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 27 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Walton Beach					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland						d. STREET ADDRESS 10 Willard Circle				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last A. B. (initials only) Smith						4. DATE OF DEATH Month Day Year August 27 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 April 1911		9. AGE (In years last birthday) 56 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sergeant in U. S. Army				10b. KIND OF BUSINESS OR INDUSTRY Armed Services		11. BIRTHPLACE (County & State, or foreign country) Georgia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John H. Smith						14. MOTHER'S MAIDEN NAME Amanda Young					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1942 - 64				16. SOCIAL SECURITY NO 255-07-8492		17. INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland 20014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Acute 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Severe Coronary Atherosclerosis DUE TO (c) NIH Type IV Hyperlipoproteinemia										INTERVAL BETWEEN ONSET AND DEATH 6 hours 10 years unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)			
21. I certify that (a) (this hospital) attended the deceased from 31 July 1967 to 27 August 1967, that (b) (we) last saw the deceased alive on 27 August 19 67, and that death occurred at 6:30 A.M. on causes and on the date stated above.											
22a. SIGNATURE Robert I. Levy M.D.						ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 28 August 1967			
22c. PHYSICIAN'S NAME (Type) Robert I. Levy, M.D.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 31, 1967		23c. NAME OF CEMETERY OR CREMATORY Forrest Cemetery				23d. LOCATION (City or town) (County) (State) Gadsden, Alabama			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, BETHESDA, MARYLAND						25a. REC'D BY REG-STRAR DATE AUG 31 1967		25b. REG-STRAR'S SIGNATURE Charles Judge			



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11312

CERTIFICATE OF DEATH

11313

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>133 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>Box 265</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Samuel Christopher Smith</u> First Middle Last		4. DATE OF DEATH <u>August 15, 1967</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 August 1955</u>
9. AGE (In years last birthday) <u>12</u> yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Emory S. Smith</u>	
14. MOTHER'S MAIDEN NAME <u>Iris Denton</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland 20014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Acute undifferentiated leukemia</u> DUE TO (c) <u>34 months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure, toxoplasmosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>we</del> (this hospital) attended the deceased from <u>April 4</u> , 19 <u>67</u> , to <u>August 15, 1967</u> , that <del>we</del> (we) last saw the deceased alive on <u>August 15, 1967</u> , and that death occurred at <u>8:00 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Creech</u> M.D.		22b. DATE SIGNED <u>15 August 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Creech, MD</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug 18/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Huntingtown Ch. Cem. Huntingtown Calvert Md.</u>	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR <u>Hutchins Funeral Home, Owings, Md.</u>		25a. REC'D BY REGISTRAR <u>William J. Jones</u> REGISTRAR'S SIGNATURE DATE <u>AUG 18 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11313

CERTIFICATE OF DEATH

11314

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>New York.</u> b. COUNTY <u>Dutchess</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pleasant Valley.</u>	
c. LENGTH OF STAY IN 1b <u>2 months</u>		d. STREET ADDRESS <u>Gleason Blvd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wilbert A. Smith</u>		4. DATE OF DEATH Month <u>8</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/19/93</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Milk Sales Rep</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Milk</u>	
11. BIRTH PLACE (County & State, or foreign country) <u>Jersey City, N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur Smith</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Marie Stanley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES W.W. I</u>		16. SOCIAL SECURITY NO <u>101-09-4160A</u>	
17. INFORMANT <u>John W. Smith, 13305 Ridge Dr. Rockville, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Thrombosis</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 yrs</u> (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/29/67</u> , 19 <u>67</u> , to <u>8/2/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/26/67</u> , and that death occurred at <u>8 P</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Robert C. Macon</u> M.D.		22b. DATE SIGNED <u>8/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. MACON</u>		22d. ADDRESS <u>809 Viers Mill Rd, Rockville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jersey City</u>	23d. LOCATION (City or Town) (County) (State) <u>Jersey City, N. J.</u>
24. FUNERAL DIRECTOR <u>Robert A. Rausley, 2052 Wisconsin Ave.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>AUG 7 1967</u>	
		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 is retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

1400  
DR REAP.  
MEDICAL EXAMINER - DR REAP.  
CLEARED

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN It <u>14 years</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admision) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>8808 Glenville Rd</u>	
3. NAME OF DECEASED (Type or print) <u>JEANNETTE MARY STANISH</u>		4. DATE OF DEATH <u>August 8 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>MARCH 5, 1906</u>	9. AGE (In years last birthday) <u>61</u> yrs. <u>61</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>WASH D.C.</u>
13. FATHER'S NAME <u>Joseph MARUCCI</u>		14. MOTHER'S MAIDEN NAME <u>Vincenta Mendez</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>E recent myocardial infarction</u> DUE TO (c)		17. <u>CONFIDENTIAL</u> <u>MR. NORMAN GENARO - 1214 Takoma Park, Md.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/27</u> <u>1967</u> to <u>August 5</u> <u>1967</u> . That (I) (we) last saw the deceased alive on <u>August 5</u> <u>1967</u> , and that death occurred at <u>10:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold W. Draper</u> M.D.		22b. DATE SIGNED <u>August 8 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>HAROLD W. DRAPER</u>		22d. ADDRESS <u>911 SILVER SPRING AVE, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 11, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Glen Carter</u> ADDRESS <u>434 Georgia Avenue</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>		DATE <u>AUG 14 1967</u>	





FOR STATE  
HEALTH DEPT.

11315

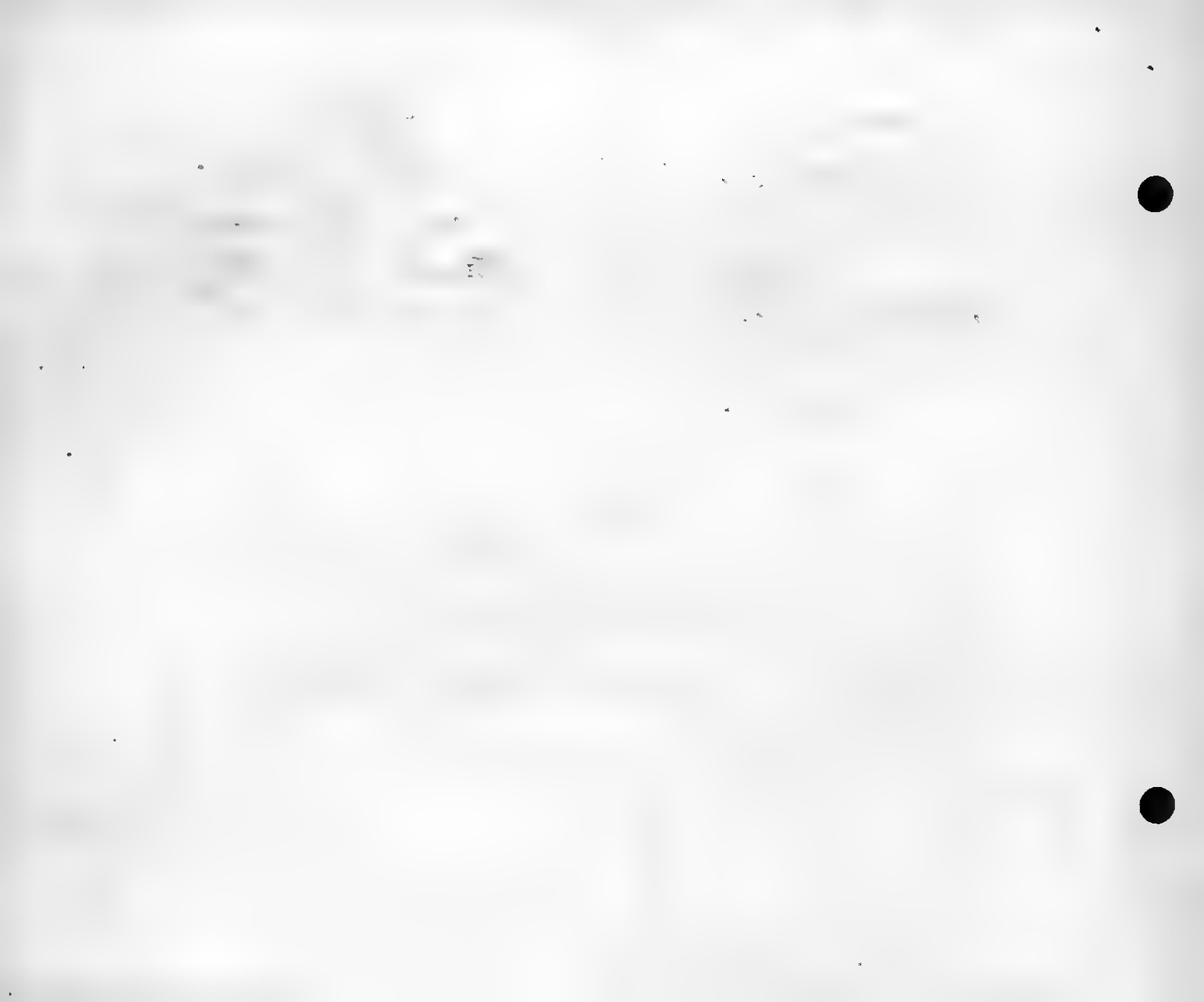
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-816

1 PLACE OF DEATH a. COUNTY <u>Mont.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if at institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. STREET ADDRESS <u>402 Blandford St.</u>	
3 NAME OF DECEASED (Type or print) <u>Jack Wayne</u>		4 DATE OF DEATH <u>Aug 28 1967</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 31 1952</u>
9 AGE (in years, last birthday) <u>14</u>		10. IF UNDER 1 YEAR Months Days Hours	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		11b. KIND OF BUSINESS OR INDUSTRY	
11c. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Samuel Staub, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Helen Hawes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mother</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Exsanguination</u> DUE TO (b) <u>laceration, left external jugular vein</u> DUE TO (c) <u>automobile accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b) <u>Passenger in car that turned over</u>		
20c. TIME OF INJURY Month, Day, Year <u>2:35 pm 19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>Dumfries Mont. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>8/29/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-31-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>AUG 31 1967</u>	25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please renumber the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11316 Time #23b Film #134 0,30,01											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON GROVE</u> c. LENGTH OF STAY IN TB <u>31</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>-</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington Grove, Md.</u> d. STREET ADDRESS <u>404 Chestnut Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Cornelius Swann</u>						4. DATE OF DEATH Month Day Year <u>8 22 1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 29, 1898</u>		9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days <u>3 23</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George Cornelius Swann, Sr.</u>						14. MOTHER'S MAIDEN NAME <u>Fannie Davis</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-10-7804</u>				17. INFORMANT Address <u>ERNEST J SWANN - WASH. GROVE, M.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of tongue</u> (c) <u>-</u> DUE TO (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>-</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1967</u> to <u>Aug 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>8/22, 1967</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>James L. Hooper</u>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>James L. Hooper, M.D.</u>						22d. ADDRESS <u>13 Deer Park Dr., Gaithersburg, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1/24/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Rockville Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>						25a. REC'D BY REGISTRAR <u>316 E. Diamond Ave</u> <u>GAITHERSBURG, MD</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> DATE <u>AUG 25 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11317

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11318

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Greece</b> b COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY in 1b <b>77 Days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Thessalonica</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>			d. STREET ADDRESS <b>Kleauthous, Street #7</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>Daisy</b> Middle <b>(NMN)</b> Last <b>Taboch</b>			4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>13 February 1916</b>		9. AGE (In years last birthday) <b>51</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Greece</b>	
13. FATHER'S NAME <b>Hanania Sabethai</b>			14. MOTHER'S MAIDEN NAME <b>Sterina Maissa</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Records</b> Address <b>20014 The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Bronchopneumonia and atelectasis</b> DUE TO (c) <b>Rheumatic Valvular Heart Disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>4 days</b> <b>23 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>31 May</b> , 19 <b>67</b> , to <b>16 August</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>16 August</b> , 19 <b>67</b> , and that death occurred at <b>8:45</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>R. Darryl Fisher MD</b>			22b. DATE SIGNED <b>17 August 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>R. Darryl Fisher, MD</b>
22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Re Burial</b>	23b. DATE THEREOF <b>8-16-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fraziers Funeral Home</b>	23d. LOCATION (City or Town) (County) (State) <b>Athens, Greece</b>		
24. FUNERAL DIRECTOR <b>Fraziers Funeral Home</b> ADDRESS <b>Washington, D.C.</b>			25a. REC'D BY REGISTRAR <b>AUG 22 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
11318 CERTIFICATE OF DEATH 1-319

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAYLOR PARK</b>			c. LENGTH OF STAY IN 1b <b>6 DAYS</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON SANITARIUM &amp; HOSPITAL</b>			d. STREET ADDRESS <b>641 HOUSTON AVE</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>MARGARET</b> First Middle Last			4. DATE OF DEATH <b>Aug 11 1967</b> Month Day Year		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>7/10/1903</b>		9. AGE (In years last birthday) <b>64 yrs.</b>		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Librarian</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>County Library</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>TENN.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		
13. FATHER'S NAME <b>WILLARD A. EISEMAN</b>			14. MOTHER'S MAIDEN NAME <b>MOZELLE CONNOLLY</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>215-22-9763</b>		
17. INFORMANT <b>TIMOTHY W. TESTER</b> (Same as #2.)			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral vascular accident</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>Day</b> <b>Day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 6, 1967</b> to <b>Aug 11, 1967</b> that (I) (we) last saw the deceased alive on <b>Aug 11 1967</b> , and that death occurred at <b>6:00 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>ALBERT H. GROLLMAN</b> M.D.			22b. DATE SIGNED <b>8/11/67</b>		
22c. PHYSICIAN'S NAME (Type or print) <b>ALBERT H. GROLLMAN</b>			22d. ADDRESS <b>1106 SPRING ST SILVER SPRING, MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug 16, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	
23d. LOCATION (City, town or county) (State) <b>Carbondale Illinois</b>					
24. FUNERAL DIRECTOR <b>Arthur Walters</b>			25a. REC'D BY REGISTRAR <b>AUG 15 1967</b>		
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

1911-12

General Account  
of the  
Department of the Interior

For the  
Fiscal Year  
1912  
By  
The  
Department of the Interior  
Washington, D. C.



## CERTIFICATE OF DEATH

11319

11330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Springs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa Nursing Home</u>				d. STREET ADDRESS <u>Earnshaw Apartments</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>PRISCILLA Hardesty THOMPSON</u>				4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1967</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-6-86</u>	9 AGE (in years last birthday) yrs <u>81</u>	IF UNDER 1 Year Months <u>2</u> Days <u>19</u> Hours <u>67</u> Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Music Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Collegiate</u>		11. BIRTHPLACE (County & State, or foreign country) <u>HARRINGTON, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William G. Hardesty</u>				14. MOTHER'S MAIDEN NAME <u>Phyllis/Richardson Eugenia Merriken</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217321946A</u>		17. INFORMANT <u>Mrs. A. L. Thompson</u> Address <u>3404 Rolling Court Chevy Chase, Maryland</u>			
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Metastatic carcinoma of the endometrium</u> DUE TO (c) <u>17</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>01</u> pm <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Dec</u> , 19 <u>66</u> to <u>Aug 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 30</u> , 19 <u>67</u> , and that death occurred at <u>8:30 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Chester Lee Roy Hagstaff</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> - MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>8-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Chester Lee Roy Hagstaff</u>				22d. ADDRESS <u>5000 Norbeck Rd., Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 5, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Joy Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Alexandria, Virginia</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 3 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



11320

CERTIFICATE OF DEATH

11321

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>4701 Flower Valley Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William B. Thompson</u>		4. DATE OF DEATH <u>8-31-67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/2/18</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>31</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner - Restaurant</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Howard Thompson</u>	
14. MOTHER'S MAIDEN NAME <u>Julia Owens</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>579-09-9948</u>		17. INFORMANT <u>Wife - Mary - Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Embolism, massive, pulmonary artery</u> DUE TO (b) <u>Cardiac arrhythmia</u> DUE TO (c) <u>Mural thrombus, right auricle due to coronary insufficiency due to coronary arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2 days</u> <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity, marked (400 lbs) and early hypostatic bronchopneumonia</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH, 1955</u> , to <u>PRESENT</u> , that (I) (we) last saw the deceased alive on <u>8/31/67</u> , and that death occurred at <u>10 A.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Charles J. Savarese, Jr.</u> M.D.		22b. DATE SIGNED <u>8/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE, JR.</u>		22d. ADDRESS <u>11125 Rockville Pike Rockville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



113281 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Birth LT. 1 lb.											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN <u>3 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Solomon Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLARKSBURG</u> d. STREET ADDRESS <u>Box 287</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Jesse Truman Thuma</u> <u>Infant Boy Thuma</u>						4. DATE OF DEATH <u>August 31</u> 19 <u>67</u> Month Day Year					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/31/67</u>		9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES TRUMAN THUMA</u>						14. MOTHER'S MAIDEN NAME <u>JULIA MAE CORDELL</u> Address <u>(Same)</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>(None)</u> 17. INFORMANT <u>(Same)</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>atelectasis, pulmonary Prematurity</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>3 hrs</u> INTERVAL BETWEEN ONSET AND DEATH											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>8/31</u> , 19 <u>67</u> to <u>8/31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/31</u> , 19 <u>67</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Francis J. Troendle</u>						22b. DATE SIGNED <u>8/31/67</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Francis J. Troendle</u> 22d. ADDRESS <u>50 W. Edmonston Dr. Rockville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>				23d. LOCATION (City, town or county) (State) <u>Gaithersburg, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>						25. REGISTRAR'S SIGNATURE <u>Charles Judge</u> REC'D BY REGISTRAR <u>SEP 6 1967</u>					



FOR STATE  
HEALTH DEPT.

11322

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
c. LENGTH OF STAY IN 1b <u>DoA</u>		d. STREET ADDRESS <u>P.O. Box 25</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>P.O. Box 25</u>		e. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Nalan</u> First <u>L</u> Middle <u>Thumma</u> Last		4 DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>1967</u>	
5 SEX <u>m</u>	6 COLOR OR RACE <u>w</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 28 - 1907</u>
9 AGE (In years past birthday) <u>60</u> yrs		IF UNDER 1 YEAR F UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Bricklayer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
10c. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>Calvin</u>		14 MOTHER'S MAIDEN NAME <u>Alberta Gilbert</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WW II Army</u>		16 SOCIAL SECURITY NO <u>217-14-7729</u>	
17 INFORMANT <u>Denzee Thumma</u>		Address <u>same as above</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gon Shot wound of Head with .22 Cal. Pistol</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Aspirated blood</u> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) <u>Shot Self in head with 22 cal. Pistol</u>	
20c. TIME OF INJURY Month Day, Year <u>4:00 pm 8/23 1967</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Gaithersburg</u>	20f. (City or town) (County) (State) <u>Montgomery Md</u>
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>8/24/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		23a. LOCATION (City or Town) (County) (State) <u>Bethesda, Md.</u>	
23a. BURIAL OR CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Park Head Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Park Head Maryland</u>
24 FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
25a. PLACE OF FUNERAL <u>1531 Rockville Pike Rockville, Md.</u>		DATE <u>AUG 28 1967</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11323

CERTIFICATE OF DEATH

1524

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5505 Charlcoate Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH TRICKETT</b>		4. DATE OF DEATH <b>Aug. 18, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 13, 1888</b>
9. AGE (In years last birthday) yrs <b>79</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>		13. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
14. FATHER'S NAME <b>Phillip C. Swarty</b>		15. MOTHER'S MAIDEN NAME <b>Helen</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>157-18-6151</b>	
18. INFORMANT <b>Husband</b>		Address <b>Same as Item 2.</b>	
19. CAUSE OF DEATH (Enter only one cause per Part I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>4 years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>August 12, 1967</b> to <b>August 18, 1967</b> , that (I) (we) lost the deceased alive on <b>August 12, 1967</b> , and that death occurred at <b>4:30 P.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>J. Blaine Fitzgerald</b>		22b. DATE SIGNED <b>8-18-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. BLAINE FITZGERALD</b>		22d. ADDRESS <b>8218 Wisconsin Ave. Bethesda, Maryland</b>	
23a. BURIAL/CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8-21-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baptist Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Salem, New Jersey</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>AUG 23 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



11324

## CERTIFICATE OF DEATH

11325

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>47 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berkeley Springs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>			d. STREET ADDRESS <u>Route 1, Box 264</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>Nahar</u> Last <u>Upshur</u>			4 DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>19 67</u>		
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>19 June 1904</u>	9. AGE (In years last birthday) <u>63</u> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>	
13. FATHER'S NAME <u>Francis Upshur</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>151-18-7442</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda, Maryland 20014</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Lymphosarcoma</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u> <u>3 1/2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home form factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from <u>July 5, 1967</u> , to <u>August 21 1967</u> , that (X) (we) last saw the deceased alive on <u>August 21, 19 67</u> , and that death occurred at <u>12:01M</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Vincent T. DeVita</u>		M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>21 August 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Vincent T. DeVita, MD.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>-24-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>H rmory</u>		23d. LOCATION (City or town) (County) (State) <u>Landoner, Md.</u>	
24. FUNERAL DIRECTOR <u>Fraziers</u>			ADDRESS <u>Washington, D. C.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 28 1967</u>
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11326

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>105 East Franklin Avenue</b>		d. STREET ADDRESS <b>105 East Franklin Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Marcia B. Van Dercook</b>		4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 30, 1917</b>
9. AGE (In years lost birthday) <b>50 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Secretary</b>		12. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	
13. BIRTHPLACE (State or foreign country) <b>Maryland</b>		14. COUNTRY OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>Robert A. Barbee</b>		16. MOTHER'S MAIDEN NAME <b>Nettie Brown</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		18. SOC. SEC. NO. <b>Yes</b>	
19. INFORMANT <b>Nelson E. Van Dercook</b>		20. ADDRESS <b>105 E. Franklin Ave. Silver Spring, Md.</b>	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>White Coronary Insufficiency</b> <b>Coronary Artery Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
22. ACTUAL SIGNATURE <b>Belden R. Reap</b>		22. DATE SIGNED <b>Aug. 5, 1967</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEP. TY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>August 7, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas</b>		25. REC'D BY REGISTRAR <b>AUG 8 1967</b>	
25a. ADDRESS <b>434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

11326

11327

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

- Seen by Dr. Maurice Siskin - regular care - August 14, 1967

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1017 Forest Glen Road</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1017 Forest Glen Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>HARRY Charles Van Tassel</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>8 - 16 1967</u> Month Day Year	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Oct. 25, 1903</u>
<b>9. AGE</b> (In years lost birthday) <u>63</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min _____		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Engineering</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Rochester, New York</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Harry J. Van Tassel</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary C. Burkhardt</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>Yes</u>	
<b>17. INFORMANT</b> <u>Mrs. Jessie C. Van Tassel</u> Address <u>1017 Forest Glen Rd Silver Spring, Md.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic asthma + bronchitis</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac decompensation</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1962</u> , 19 <u>62</u> , to <u>August 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 27 1967</u> , and that death occurred at <u>10:45</u> A.M., from causes and on the date stated above.	
<b>22a. SIGNATURE</b> <u>Bennet A. Porter, Jr.</u> M.D.		<b>22b. DATE SIGNED</b> <u>August 16, 1967</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Bennet A. Porter, Jr.</u>		<b>22d. ADDRESS</b> <u>9301 Colesville Rd., Silver Spring, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial - Transit</u>		<b>23b. DATE THEREOF</b> <u>Aug. 22, 1967</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Warner E. Humphrey Funeral Home</u>		<b>23d. LOCATION (City or Town)</b> (County) (State) <u>Covina, California</u>	
<b>24. FUNERAL DIRECTOR</b> <u>E. Glen Carter</u> ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>AUG 28 1967</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		<b>25c. REGISTRAR'S NAME</b> <u>Charles Judge</u>	





11327

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 2-1328

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN TB <u>3 mos 20 min</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d STREET ADDRESS <u>9110 Bell Farm Parkway</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Lestie J Venable</u>		4 DATE OF DEATH Month Day Year <u>August 30 19 67</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4 March 1901</u>
9 AGE (In years, lost birthday, yrs) <u>66</u>		10 IF UNDER 1 YEAR Months Days Hours Min <u>19 67</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>John W. Venable</u>		14 MOTHER'S MAIDEN NAME <u>Elizabeth Ford</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>44-10-7208</u>	
17 INFORMANT <u>Louise Venable</u>		Address <u>same as above</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aneurysm, abdominal aorta, ruptured</u> DUE TO (b) <u>arteriosclerosis, generalized, severe</u> DUE TO (c) <u>arteriosclerosis, generalized, severe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> hot While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22 DATE SIGNED <u>Aug 31, 1967</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a BURIAL (CREMATION REMOVAL) (Specify) <u>Burial</u>		23b DATE THEREOF <u>9-2-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u>	
24 FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a REC'D BY REG. STRAR DATE <u>SEP 8 1967</u>	
		25b REG. CLERK'S SIGNATURE <u>William J. Judge</u>	



11328

## CERTIFICATE OF DEATH

11329

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Rural</b>		c. LENGTH OF STAY IN It <b>7 Days</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Prince William</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. STREET ADDRESS <b>246 Third Ave.</b>		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN EDWARD WADDICK</b>		4. DATE OF DEATH <b>AUG 26 19 67</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>Cauc</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>June 15, 1906</b> 9. AGE (In years last birthday) <b>61</b> yrs IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Military</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Marine Corps</b>		11. BIRTHPLACE (County & State or foreign country) <b>Chicago, Illinois</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Francis Waddick</b>		14. MOTHER'S MAIDEN NAME <b>Emma Pokrant</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> 16. SOCIAL SECURITY NO. <b>224-54-3049</b> 17. INFORMANT <b>Marjorie Waddick (Wife)</b> Address <b>246 3rd Ave Quantico, Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Cerebral Infarction</b> DUE TO <b>Arteriolosclerotic Hypertensive Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Disease</b> (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 19, 19 67</b> to <b>Aug 26, 19 67</b> , that (I) (we) last saw the deceased alive on <b>Aug 26, 19 67</b> , and that death occurred at <b>2:30 AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Peter T. Kirchner</b>		22b. DATE SIGNED <b>27 August 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Peter T. KIRCHNER</b>	
22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>		22e. REC'D BY REGISTRAR <b>Charles Judge</b> 22f. REGISTRAR'S SIGNATURE			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>30 AUG 67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
23d. LOCATION (City or Town) <b>Arlington, Virginia</b>		23e. LOCATION (County) (State)			
24. FUNERAL DIRECTOR <b>Cunningham-Montcastle</b>		ADDRESS <b>Woodbridge, Va.</b>		25. REC'D BY REGISTRAR <b>AUG 31 1967</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS 14  
 20M 5-63

MEDICAL CERTIFICATION

14328 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
Item 3 Film 0392 8/24/67 kk										11330			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>						c. LENGTH OF STAY IN TB <u>5 months</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brooke Grove Foundation, Olney, Md</u>						d. STREET ADDRESS <u>Gaithersburg</u> <u>100 Central Avenue</u>							
3. NAME OF <u>Elizabeth</u> First <u>Pricilla</u> Middle <u>Walker</u> Last						4. DATE OF DEATH <u>August</u> <u>17</u> <u>1967</u>							
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 8, 1890</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MONTGOMERY, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13. FATHER'S NAME <u>THADIS BUZZARD</u>						14. MOTHER'S MAIDEN NAME <u>Pricilla MURPHY</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>213-50-7412</u>		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (b) <u>ASCVD</u> (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe chronic brain syndrome &amp; senility</u>												INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1967</u> to <u>Aug 17, 1967</u> that (I) (we) last saw the deceased alive on <u>7-29</u> <u>1967</u> and that death occurred at <u>2 AM</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Frederick Moomau</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-17-67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Frederick Moomau, M.D.</u>						22d. ADDRESS <u>Medical Center, Sandy Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)							
<u>Burial</u>		<u>Aug. 19, 1967</u>		<u>Mt. Olivet Cemetery</u>		<u>Frederick, Maryland</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Gaithersburg Funeral Home</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE					
ADDRESS <u>366 Diamond</u>						DATE <u>AUG 21 1967</u>							
<u>Gaithersburg, Md.</u>													



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11331

11330

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>3115 Myers mill Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Frederick E. Walker Jr.</u>		4. DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-23</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Comp Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Florida</u>	9. AGE (In years last birthday) <u>43</u> yrs
13. FATHER'S NAME <u>Frederick E Walker, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>GRACE L. ECCLESTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>111-860944-100</u>	
17. INFORMANT <u>THOMAS WALKER, TAMASCUS, MD.</u>		18. ADDRESS	
19. INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF F.T.H.R., NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/1/66</u> , 19 <u>66</u> , to <u>8/26/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/24/67</u> , 19 <u>67</u> , and that death occurred at <u>4 A</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Frederick E. Walker, Jr., M.D.</u>		22b. DATE SIGNED <u>8/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frederick E. Walker, Jr.</u>		22d. ADDRESS <u>11118 Leesylvania Rd., Potomac, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral Home</u>	23b. DATE THEREOF <u>Aug 29-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>	23d. LOCATION (City or town) (County) (State) <u>Montgomery, Md.</u>
24. FUNERAL DIRECTOR <u>Frederick E. Walker, Jr.</u>		25. REC'D BY REGISTRAR <u>James J. Judge</u>	
26. ADDRESS <u>250 Carroll St NW Washington D.C.</u>		27. DATE <u>AUG 31 1967</u>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M '67

11331

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD.</u> b COUNTY <u>Mont.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>D.C.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>8400 Wisconsin Ave.,</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Urcle O. Jack Wamsley</u>		4 DATE OF DEATH Month Day Year <u>August 9, 19 67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/30/1899</u>
9 AGE (In years, not birthday) <u>67</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min <u>19 67</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen. Manager</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Governor House Motel</u>	
11 BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Charles Wamsley</u>		14 MOTHER'S MAIDEN NAME <u>Vinnie Fisher</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes 1st &amp; 2nd W.W.</u>		16 SOCIAL SECURITY NO. <u>578-09-2234</u>	
17 INFORMANT <u>Freda Wamsley, wife</u>		Address <u>Same as Item 2.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fatty metamorphosis - of Liver.</u> DUE TO (b) <u>Chronic alcoholism</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>Years.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
22. DATE SIGNED <u>Aug 9, 1967</u>			
23a BURIAL (CREMATION, REMOVAL) (Specify) <u>Burial</u>	23b DATE THEREOF <u>8-12-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24 FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a REC'D BY REGISTRAR DATE <u>AUG 21 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 27 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film 4191 8/27/67 kk

CERTIFICATE OF DEATH

11332

11334

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		d. STREET ADDRESS <u>3638 16th St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>John Samuel West</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEP 17 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVERNMENT</u>	9. AGE (In years last birthday) <u>89</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John S. West</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Mulligan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>574-60-6833</u>	
17. INFORMANT <u>Mrs. Walter A. Brown</u>		Address <u>121 Primrose St. NW Chevy Chase</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>431X Dissecting aneurysm of aorta</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>4 YRS.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1966</u> to <u>Aug 1967</u> that (I) (we) last saw the deceased alive on <u>Aug 15 1967</u> , and that death occurred at <u>6:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond T. Benack MD</u>		22b. DATE SIGNED <u>8/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond T. Benack MD</u>		22d. ADDRESS <u>4115 Colie Dr. Wheaton MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-17-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>Joseph Yankin Sons Washington D.C.</u>		25. RECEIVED BY REGISTRAR <u>AUG 17 1967</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		27. REGISTRAR'S SIGNATURE	

5



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20 M 1/66

1  
11333  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #3 Film #3391 6/1/67 ph  
11335

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, DC		b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN lb 1 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N. W. (section)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home				d. STREET ADDRESS 2301 11th St., NW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Benyon West				4. DATE OF DEATH 8/13/67		19	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1933 7/18/1884	
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dean		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Sparta, Ga.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry West				14. MOTHER'S MAIDEN NAME Minnie Harley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO UNWT Army 578-44-6847		17. INFORMANT Address Washington, DC Mrs. Virginia West-2301 11th St., NW			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fracture left tibia, right clavicle, dislocation pubis</u>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by auto mobile</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 3/9 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) Washington, D.C.	
21. I certify that (I) (this hospital) attended the deceased from 3/9, 1967, to 7/7, 1967, that (I) (we) last saw the deceased alive on 7/7, 1967, and that death occurred at 4 P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Sanford H. Eisenberg</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Aug 14 '67	
22c. PHYSICIAN'S NAME (Type) Dr. S. Eisenberg				22d. ADDRESS 1918 K St., NW, Wash., DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-17-67		23c. NAME OF CEMETERY OR CREMATORY Harmony Park		23d. LOCATION (City or town) (County) (State) Landover Md	
24. FUNERAL DIRECTOR Rollins Inc 4339-Hunt PK NE				25a. REC'D BY REGISTRAR DATE AUG 16 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge	



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and to prevent within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11334

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11336

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Grove</u>		c. LENGTH OF STAY IN <u>1 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Salem Methodist Church</u>				d. STREET ADDRESS <u>9069 Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard Cornwell Whiteman</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1916</u>	9. AGE (In years last birthday) <u>51</u> yrs	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>		IF UNDER 24 HRS Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>New Mexico</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>A. L. Whiteman</u>				14. MOTHER'S MAIDEN NAME <u>Margaret E. Cornwell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-24-0689</u>		17. INFORMANT Address <u>Gerald Frick, Potomac, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <u>1975 Congenital Heart Defect</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <u></u> (b) <u></u> DUE TO (c) <u></u> DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>5191</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>		EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>8/1/67</u>	
23a. B. J. RIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 4, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City or Town) (County) (State) <u>Frederick, Md.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Olin L. Molesworth, Damascus, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





11335

## CERTIFICATE OF DEATH

11337

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, MD.</u> c. LENGTH OF STAY IN TB <u>151</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>Fuller Street</u> <u>12213 Silver Spring Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ISRAEL</u> First Middle Last 4. DATE OF DEATH <u>August 27</u> 19 <u>67</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3/12/1907</u> 9. AGE (In years last birthday) <u>60</u> yrs IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HISTORICIAN</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>PENNA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>LOUIS WICE</u> 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO <u>578-32-0671</u> 17. INFORMANT <u>PAUL WICE</u> Address <u>2001 FRANKLIN, ST.</u> <u>ALEX, VA.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>8/20</u> , 19 <u>67</u> , to <u>8/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/26</u> , 19 <u>67</u> , and that death occurred on <u>8/27</u> AM, from causes and on the date stated above 22a. SIGNATURE <u>Denne H. Bender</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>8/27/67</u> 22c. PHYSICIAN'S NAME (Type) <u>10820 GA Ave Wheaton, MD.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>8/29/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEM. HIGHTSVILLE, MD.</u> 23d. LOCATION (City or Town) (County) (State) <u>Goldberg Funeral Home 4217-9th St. S.W.</u> 25a. REC'D BY REGISTRAR DATE <u>AUG 29 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J. [Signature]</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in absence, within 72 hours after death.

VR A15 (■)  
20 M 1/66



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11336

CERTIFICATE OF DEATH

11338

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac Valley Nursing Home</b>		d. STREET ADDRESS <b>4144 Great Oak Road</b>	
3. NAME OF DECEASED (Type or print) <b>BEATRICE</b> First Middle Last <b>WIEBE</b>		4. DATE OF DEATH <b>August 16, 1967</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 28, 1889</b> 9. AGE (In years lost birthday) <b>77</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Indiana</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Basil B. Spradley</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Pitman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>317-26-7641D</b>	
17. INFORMANT <b>Thelma J. Obert-Item # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>1931 IMMEDIATE CAUSE (a) <i>Carcinomatous</i></b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>(b) DUE TO <i>Carcinoma, spinal cord, primary</i></b> <b>(c) <i>Carcinoma, spinal cord, primary</i></b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b> <b>2 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1967</b> , 19 to <b>Aug 16, 1967</b> , that (I) (we) last saw the deceased alive on <b>Aug 11, 1967</b> , and that death occurred at <b>10:20 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Ashby W. Smith</b>		22b. DATE SIGNED <b>8/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ashby W. Smith</b>		22d. ADDRESS <b>13018 Georgia Ave., Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>	23b. DATE THEREOF <b>8/19/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>	23d. LOCATION (City or Town) (County) (State) <b>Evansville, Indiana</b>
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1551 Rockville Pike</b> <b>Rockville, Maryland</b>		25a. REC'D BY REGISTRAR <b>AUG 21 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11337

11339

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
c. LENGTH OF STAY IN 1b <u>30 yrs</u>		d. STREET ADDRESS <u>Box 92</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>GLADYS ESTELLE WINES</u>		4 DATE OF DEATH <u>Aug 17 1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug 18 - 1919</u>
9 AGE (In years, months, days, hours, minutes) <u>47 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Buyer</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Farmers Co Va</u>		12 CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John FRANKLIN WINES</u>		14. MOTHER'S MAIDEN NAME <u>ADDIE MARIE TAYLOR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>139-20-8695</u>	
17. INFORMANT <u>BROTHER</u>		Address <u>1600 Maple Ave Rockville, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>1537 INANITION</u>			
DUE TO (b) <u>CANCER OF COLON</u>			
DUE TO (c) <u>1 yr</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , 19 <u>present</u> to <u>present</u> (I) (we) last saw the deceased alive on <u>8-13</u> 19 <u>67</u> , and that death occurred <u>8-17</u> AM, from causes and on the date stated above			
22a. SIGNATURE <u>DRA. F. CASTRO</u>		22b. DATE SIGNED <u>8-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DRA. F. CASTRO</u>		22d. ADDRESS <u>916 - 19th St NW DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1951 Rockville, Maryland</u>		25. REC'D BY REGISTRAR <u>Charles Juge</u>	
DATE <u>AUG 21 1967</u>		25b. REGISTRAR'S SIGNATURE	



11338

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>1 month + 2 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>8523 Glenview Ave. Apt. 203</u>	
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>NMN</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6 COLOR OR RACE <u>Caucasian</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1887</u> <u>Oct. 29, 1887</u>
9 AGE (In years last birthday) <u>79</u> <u>80000</u> yrs		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none - Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>own home none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>XXXXXXXXXX Wash. D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Wurdeman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Volland</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>577-05-0856</u>	
17 INFORMANT <u>Wife - MARY Wurdeman</u>		Address <u>8105 Flower Ave. T.P. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Probable lymphoma</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-16</u> , 19 <u>67</u> , to <u>8-18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-18</u> , 19 <u>67</u> , and that death occurred at <u>6:45</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>John B. Thomas</u>		22b. DATE SIGNED <u>8-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DANISH</u>		22d. ADDRESS <u>1106 Spring St S.E. Md</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 22, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a REC'D BY REGISTRAR <u>Aug 28 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>Warner E. Pumphrey Funeral Home Silver Spring, Md</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11341

11339

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>	
c. LENGTH OF STAY IN 1b <u>7 days</u>		d. STREET ADDRESS <u>11905 Colin Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Matilda Toby Wolitzky</u>		4. DATE OF DEATH <u>August 7 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-88</u>
9. AGE (In years lost birthday) <u>67 yrs</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Romania</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Morris Leibowitz</u>		14. MOTHER'S MAIDEN NAME <u>Eva ? ? ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Hospital chart</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute myocardial infarction - 1hr</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>Diabetes mellitus</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Sym. 1 hr</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 5, 1965</u> to <u>AUG 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>AUG 7, 1967</u> , and that death occurred at <u>4:00 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Myron L. Lenkin</u> M.D.		22b. DATE SIGNED <u>8-7-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MYRON L. LENKIN</u>		22d. ADDRESS <u>2309 SHOREFIELD RD. WHEATON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-9-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WATKINS MEMORIAL PARK</u>	23d. LOCATION (City or Town) (County) (State) <u>FALLS CHURCH VA.</u>
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		25a. REC'D BY REGISTRAR <u>4217-9th St. N.W. Wash. D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 10 1967</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

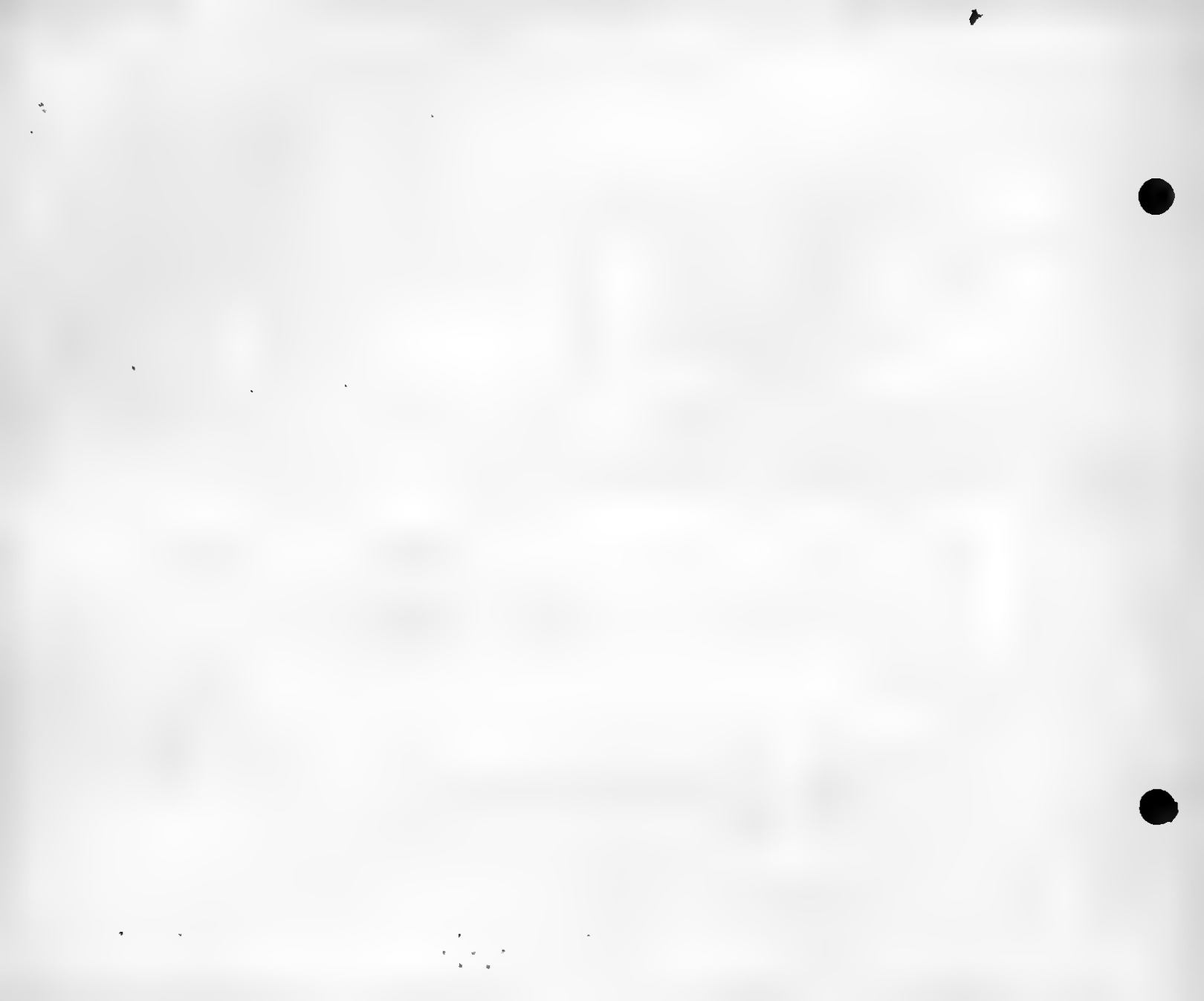
VR A15ME (5)  
6M 1/67

11340

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11342

1. PLACE OF DEATH a. CITY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TACOMA PARK</u> c. LENGTH OF STAY IN 1b <u>11 DAYS</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Dist. of Columbia</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN. &amp; HOSPITAL</u>		d. STREET ADDRESS <u>1513 Allison St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>EDITH</u> First Middle Last <u>WRIGHT</u>		4. DATE OF DEATH Month Day Year <u>Aug. 15 1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-13-81</u>
9. AGE (In years last birthday) <u>85</u> yrs		F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Wright</u>	
14. MOTHER'S MAIDEN NAME <u>Ellen Clark</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>578-62-4540</u>		17. INFORMANT Address <u>HOSP. RECORDS</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolism and</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute bronchopneumonia</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> MD		22. DATE SIGNED <u>8/15/1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		Address (Street, city, town or county) <u>Washington</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u>	23d. LOCATION (City or town) (County) (State) <u>WASHINGTON, D.C.</u>
24. FUNERAL DIRECTOR <u>Robert J. ...</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 18 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11343

11341

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) b. STATE <b>District of Columbia</b> c. COUNTY <b>Washington</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>126 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>5507 Albia Rd. 20016</b>	
3 NAME OF DECEASED (Type or print) <b>George Charles Wright</b>		4. DATE OF DEATH Month <b>8</b> Day <b>7</b> Year <b>67</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3 Aug 1902</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Military-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USN</b>	9 AGE (In years lost (day) yrs) <b>65</b>
11 BIRTHPLACE (County & State, or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Cyrus Wright</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hamilton</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes Retired</b>		16. SOCIAL SECURITY NO <b>262-60-8105</b>	
17. INFORMANT <b>Mrs Estelle Wright</b>		Address <b>5507 Albia Rd. WDC</b>	
18. CAUSE OF DEATH (Enter only one line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. <b>237X Brain Tumor</b> IMMEDIATE CAUSE (a) <b>Brain Tumor</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3 April</b> , 19 <b>67</b> , to <b>7 August</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>7 August</b> , 19 <b>67</b> , and that death occurred at <b>7:50 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>B.M. Onofrio</b>		22b. DATE SIGNED <b>8 August 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>B.M. Onofrio</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8-10-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>
24 FUNERAL DIRECTOR <b>Gawlers Funeral Home 5130 Wisconsin Ave WDC</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 11 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



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clear void medical examiner

CERTIFICATE OF DEATH

11342

11344

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>Hours</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>				e. STREET ADDRESS <b>3501 Leisure World Blvd.</b>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Burton</b> Last <b>Zachary</b>				4. DATE OF DEATH Month <b>8</b> Day <b>18</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/6/02</b>	9. AGE (in years lost birthday) yrs. <b>64</b>	IF UNDER 1 YEAR Months <b>18</b> Days <b>18</b> Hours <b>67</b> Min	IF UNDER 24 HRS Hours <b>67</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas Co.</b>		11. BIRTHPLACE (County & State or foreign country) <b>Alexandria, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Southey P. Zachary</b>				14. MOTHER'S MAIDEN NAME <b>Maude Zachary</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>577-07-7407</b>		17. INFORMANT Address <b>World Blvd.</b> <b>Mable C. Zachary 3501 Leisure</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary atherosclerosis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>18 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work or <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>May 1949</b> , to <b>Aug 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>Aug 9, 1967</b> , and that death occurred at <b>6:42 M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>8/18/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>H F Kreuzburg</b>				22d. ADDRESS <b>7852 16<sup>th</sup> New World Dr</b>			
23a. BURIAL, CREMATION, REMOVA. (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug 21, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Glen Carter</b> <b>Warner E. Pumphrey, Inc.</b>				25a. REC'D BY REGISTRAR <b>8434 Georgia Avenue</b> <b>Silver Spring, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-13. Page 5 may be retained for your files.  
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VR A15ME (5)  
6M 1/67

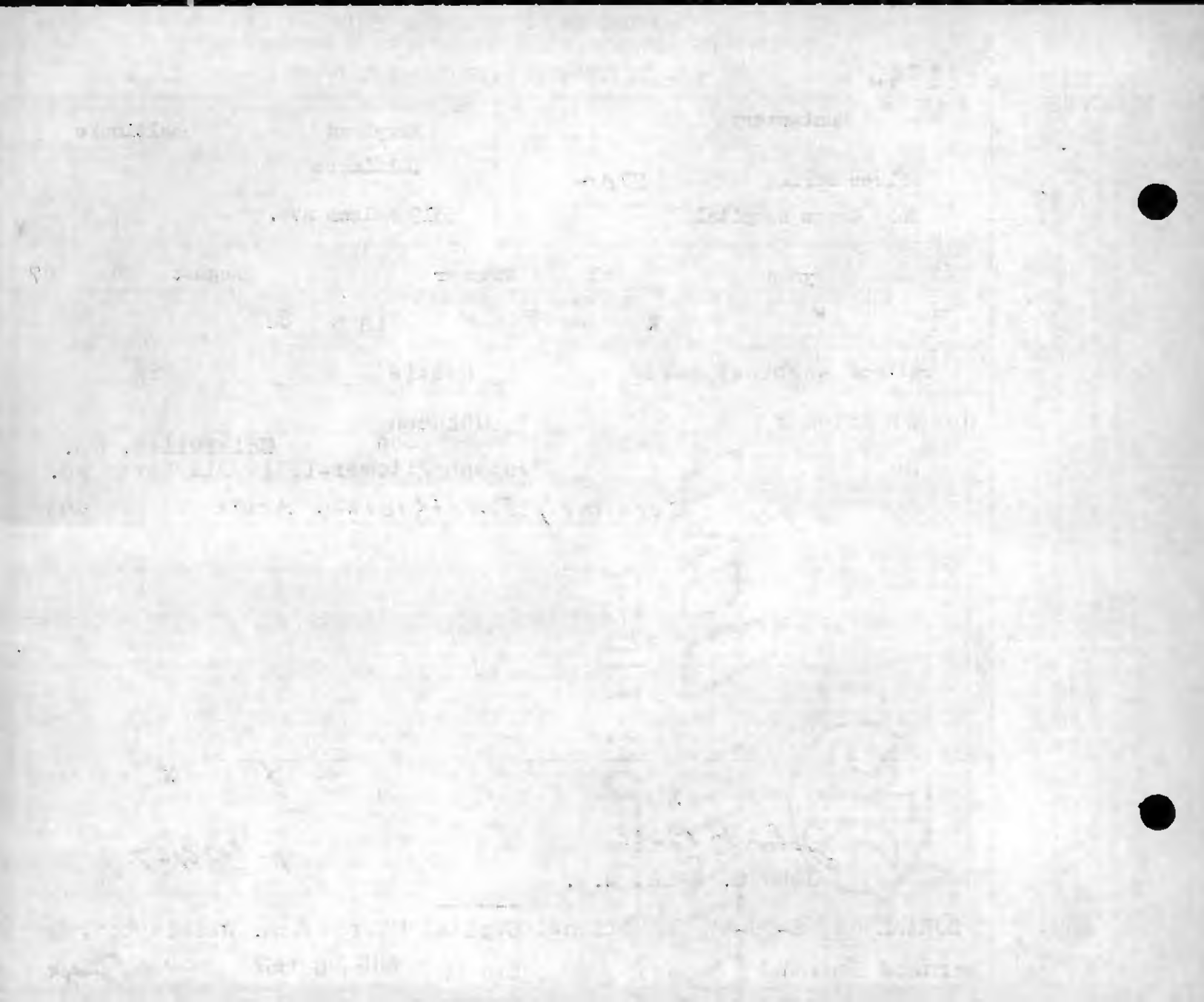
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11343

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11345

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>DOA.</b>		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>5519 Nelson Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Hyman NMI Zitomer</b>		4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>1967</b>	
5. SEX <b>m</b>	6. COLOR OR RACE <b>w</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1885</b>
9. AGE (In years last birthday) yrs. <b>82</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired -cabinet maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Zitomer</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Son</b> <b>Joseph Zitomer-13312 Old Forge Rd.</b>		Address <b>Golesville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Coronary Insufficiency Acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4201</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b> EXAMINER'S NAME (Type) <b>JOHN G. BALL, M.D.</b>		22. DATE SIGNED <b>8/28/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-29-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>National Capital Hebrew Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, DC</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Bernard Danzansky &amp; Sons Washington DC</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 30 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



11344

## CERTIFICATE OF DEATH

11346

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN 1b <b>Chevy Chase</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5221 Mass. Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Zombory</b> Last <b>Zombory</b>		4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>1967</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 July 1880</b>
9. AGE (In years last birthday) yrs. <b>87</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b> Hours <b>30</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hungary</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>Hungary</b>	
13. FATHER'S NAME <b>Gyorgy Radacsy</b>		14. MOTHER'S MAIDEN NAME <b>Eliz Balint</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>577 68 5789</b>	
17. INFORMANT <b>Daughter - Margaret Beky - Same as #1</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST, CONGESTIVE HEART FAILURE</b> DUE TO <b>HYPERTENSIVE &amp; ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ESSENTIAL HYPERTENSION &amp; ARTERIOSCLEROSIS</b> (c) <b>20 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>10-15 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MARKED OBESITY, OLD, RECURRENT CHRONIC DIARRHEA 8-10 years AGE.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) *****	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>December 1965</b> , to <b>August 15, 1967</b> , that (I) (we) last saw the deceased alive on <b>August 15, 1967</b> , and that death occurred at <b>3:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>FRANK S. HORVATH, M.D.</b>		22b. DATE SIGNED <b>August 16, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>FRANK S. HORVATH, M.D.</b>		22d. ADDRESS <b>4966 Mac Arthur Boulevard, N.W. Washington, D.C. 20007</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 19, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery,</b>		23d. LOCATION (City or Town) (County) (State) <b>Trenton, New Jersey</b>	
24. FUNERAL DIRECTOR <b>H. Hon. Delo</b>		25a. REC'D BY REGISTRAR <b>2222 Wis. Ave. N.W.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>AUG 22 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.  
OFFICE OF THE SECRETARY  
ATTENTION: ASSISTANT SECRETARY FOR  
GENERAL AFFAIRS  
MAIL ROOM  
MAIL STOP 100  
WASHINGTON, D.C. 20250

THOMAS W. HARRIS